# AMENDED MARKET CONDUCT EXAMINATION REPORT
# AS OF DECEMBER 31, 2009

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## UNITEDHEALTHCARE OF COLORADO, INC.
**6465 South Greenwood Plaza Blvd.**
**Centennial, CO 80111**

**NAIC Company Code 95090**
**NAIC Group Code 707**

**CONDUCTED BY:**

**COLORADO DIVISION OF INSURANCE**

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**UNITEDHEALTHCARE OF COLORADO, INC.**
**6465 South Greenwood Plaza Blvd.**
**Centennial, CO 80111**

# AMENDED MARKET CONDUCT EXAMINATION REPORT
**as of**
**December 31, 2009**

**Examination Performed by:**

**Regulatory Consultants, Inc.**

**Nestor J. Romero, CPA, CFE, CIE**
**Examiner-In-Charge**

**Jimmy Potts, FLMI, CLU, AIRC, CIE**

**Charlotte Howell, CIE**

August 17, 2010

The Honorable Marcy Morrison
Commissioner of Insurance
State of Colorado
1560 Broadway, Suite 850
Denver, Colorado 80202

Commissioner Morrison:

A market conduct examination of UnitedHealthcare of Colorado, Inc. (the Company) was conducted pursuant to §§ 10-1-203, 204, and 205, C.R.S., as well as §§ 10-3-1106, and 10-16-416, C.R.S., which authorize the Insurance Commissioner to examine insurance companies and health maintenance organizations (HMO's). The examination was conducted at the home offices of the independent examiners in Idaho and Arizona.

The examination covered the period from January 1, 2009, through December 31, 2009 and included a review of the Company's operations and management and contract forms.

The following market conduct examiners respectfully submit the results of the examination.

Nestor J. Romero, CPA, CFE, CIE

Jimmy Potts, FLMI, CLU, AIRC, CIE

Charlotte Howell, CIE

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## COMPANY PROFILE

The following profile is based on information provided by the Company:

UnitedHealthcare of Colorado, Inc. (UHcCO or Company) has its principal executive office at 6465 South Greenwood Plaza Boulevard, Suite 300, Centennial, CO, 80111-4722. UHcCO was incorporated in Colorado on February 24, 1986, under the name MetLife HealthCare Network of Colorado, Inc. and commenced operations as a health maintenance organization in Colorado on March 20, 1986.

UHcCO was a wholly owned subsidiary of MetLife HealthCare Management Corporation ("MHMC"), a Delaware corporation and wholly owned subsidiary of Metropolitan Life Insurance Company. On July 11, 1995, as a result of the formation of The MetraHealth Companies, Inc., by Metropolitan Life Insurance Company and The Travelers, Inc., MetLife HealthCare Network of Colorado, Inc. changed its name to The MetraHealth Care Plan of Colorado, Inc. On June 7, 1995, MHMC changed its name to MetraHealth Care Management Corporation. On November 1, 1999, the Colorado Division of Insurance granted permission for MHMC to transfer its ownership of UHcCO to UnitedHealthcare, Inc., a Delaware corporation and wholly owned indirect subsidiary of United HealthCare Corporation ("United"), a Minnesota corporation incorporated in January 1977. On March 7, 2000, United changed its name to UnitedHealth Group Incorporated. Effective September 30, 2000, UHcCO became a wholly owned direct subsidiary of UnitedHealthcare, Inc. ("UHc"), a Delaware corporation and wholly owned indirect subsidiary of United.

As of September 2010 the Company was assigned an A. M. Best financial strength rating of A- (Excellent).

UnitedHealthcare of Colorado, Inc. is licensed to operate as a health maintenance organization in Colorado.

Premium and Market Share as of December 31, 2009:

| | |
|---|---|
| Total Written Premium: | $2,645,000* |
| Small Group Written Premium: | $2,514,000** |

Market Share

(as a percentage of Colorado Total Accident and Health): 0.03% *
(as a percentage of Colorado Total Small Group): 0.20%

* As shown in the 2009 Edition of the Colorado Insurance Industry Statistical Report
** As provided by the company to the Division in the Health Cost Report

## PURPOSE AND SCOPE

Independent contract examiners for the Colorado Division of Insurance (Division), in accordance with Colorado insurance laws, §§ 10-1-203, 204, and 205, C.R.S., as well as §§ 10-3-1106, and 10-16-416, C.R.S., which empower the Commissioner to examine any entity engaged in the insurance business, reviewed certain business practices of UnitedHealthcare of Colorado, Inc.. The findings in this report, including all work products developed in producing it, are the sole property of the Division.

The purpose of the examination was to determine the Company's compliance with Colorado insurance laws related to insurance companies. Examination information contained in this report should serve only these purposes. The conclusions and findings of this examination are public record. The preceding statements are not intended to limit or restrict the distribution of this report.

The examiners conducted the examination in accordance with procedures developed by the Colorado Division of Insurance, based on model procedures developed by the National Association of Insurance Commissioners. In reviewing material for this report the examiners relied primarily on records and materials maintained and/or supplied by the Company. The market conduct examination covered the twelve (12) month period from January 1, 2009, through December 31, 2009 and included a review of the following:

Company Operations and Management
Contract Forms

Upon review of each area any concerns or discrepancies were noted on comment forms and delivered to the Company for review. Once the Company was advised of a finding contained in a comment form, the Company had the opportunity to respond. For each finding, the Company was requested to agree, disagree or otherwise justify the Company's noted action. At the conclusion of each review, the Company was provided a summary of the findings related to each area. The examination report is a report by exception. Therefore, much of the material reviewed is not addressed in this written report. References to any practices, procedures, or files which manifested no improprieties were omitted.

The examiners reviewed all policy forms, applications and Health Plan Description forms in use by the Company during the examination period.

Certain unacceptable or non-complying practices may not have been discovered in the course of this examination. Additionally, findings may not be material to all areas that would serve to assist the Commissioner. Failure to identify or criticize specific Company practices does not constitute acceptance of such practices by the Division. Examination findings may result in administrative action by the Division.

A copy of the Company's official response to this final market conduct report, if applicable, can be obtained upon request from the Division.

Results of previous market conduct examinations are available on the Division's website at www.dora.state.co.us/insurance or by contacting the Division.

## METHODOLOGY

The examiners reviewed the Company's business practices to determine compliance with Colorado insurance laws. For this examination, special emphasis was given to the statutes and regulations as shown below.

| Statute or Regulation | Subject |
|---|---|
| Section 10-1-128, C.R.S. | Fraudulent insurance acts – immunity for furnishing information relating to suspected insurance fraud – legislative declaration. |
| Section 10-3-1104, C.R.S. | Unfair methods of competition and unfair or deceptive acts or practices. |
| Section 10-16-102, C.R.S. | Definitions. |
| Section 10-16-104, C.R.S. | Mandatory coverage provisions – definitions. |
| Section 10-16-104.7, C.R.S. | Substance abuse – court-ordered treatment coverage. |
| Section 10-16-104.8, C.R.S. | Mental health services coverage – court-ordered. |
| Section 10-16-105, C.R.S. | Small group sickness and accident insurance – guaranteed issue – mandated provisions for basic health benefit plans – rules – benefit design advisory committee - repeal. |
| Section 10-16-108, C.R.S. | Conversion and continuation privileges. |
| Section 10-16-113.5, C.R.S. | Independent external review of benefit denials – legislative declaration – definitions. |
| Section 10-16-118, C.R.S. | Limitations on preexisting condition limitations. |
| Section 10-16-407, C.R.S. | Information to enrollees. |
| Section 10-16-704, C.R.S. | Network adequacy - rules - legislative declaration - repeal. |
| Section 10-16-705, C.R.S. | Requirements for carriers and participating providers. |
| Insurance Regulation 1-1-6 | Concerning The Elements Of Certification For Accident and Health Forms, Private Passenger Automobile Forms, Commercial Automobile with Individually-owned Private Passenger Automobile-Type Endorsement Forms, Claims-Made Liability Forms and Preneed Funeral Contracts |
| Insurance Regulation 1-1-7 | Market Conduct Record Retention |
| Insurance Regulation 1-1-8 | Penalties And Timelines Concerning Division Inquiries And Document Requests |
| Insurance Regulation 4-2-5 | General Hospital Definition |
| Insurance Regulation 4-2-8 | Concerning Required Health Insurance Benefits for Home Health Services and Hospice Care |
| Insurance Regulation 4-2-13 | Mammography Minimum Benefit Level |
| Insurance Regulation 4-2-16 | Women's Access to Obstetricians and Gynecologists under Managed Care Plans |
| Insurance Regulation 4-2-17 | Prompt Investigation of Health Plan Claims Involving Utilization Review and Denial Of Benefits |
| Insurance Regulation 4-2-20 | Concerning the Colorado Health Benefit Plan Description Form |
| Insurance Regulation 4-2-21 | External Review of Benefit Denials of Health Coverage Plans |
| Emergency Regulation 08-E-12 | Concerning Small Employer Group Health Benefit Plans and the Basic and Standard Health Benefit Plans |
| Insurance Regulation 4-6-5 | Concerning Small Employer Group Health Benefit Plans and the Basic and Standard Health Benefit Plans |
| Insurance Regulation 4-6-7 | Concerning Premium Rate Setting for Small Group Health Plans |
| Insurance Regulation 4-6-8 | Concerning Small Employer Health Plans |
| Insurance Regulation 4-6-9 | Concerning Conversion Coverage |

**Company Operations and Management**

The examiners reviewed Company timely cooperation with the examination process.

**Audits and Examinations**

The Company was the subject of a previous market conduct examination dated August 28, 2009, which covered the period January 1, 2007 through December 31, 2007. This prior examination did not include a review of policy forms.

**Contract Forms**

The examiners reviewed the following forms:

2009 Basic Health Benefit Plan (Group Forms), twenty-three (23) Members

| Form Name | Form Number |
|---|---|
| CO Basic and Standard Group Policy | PolicyBSCSTD.H.07.CO |
| HMO Basic Limited Mandate Health Benefit Plan for Colorado – Certificate | BasChcCOC.H.07.CO |
| Hearing Aid Rider Basic and Standard HMO | 1109HEARINGAID.BCSSTD.AMD.H.07.CO |
| 7/1/09 Colorectal Cancer Screening COC Amendment –2007 Series Basic and Standard HMO | COLORECTAL.AMD.H.07.CO.BSCSTD |
| MCE 2009 Amendment – Basic HMO SB COC | MCE09BSCHMOSB.AMD.H.07.C0 |
| MCE 2009 Amendment (Sept) – Basic and Standard HMO SB.COC | MCE09BSCSTDHMOSBSEPT.AMD.H.07.CO |
| MCE 2009 Correction – Basic HMO SB Medical SOB | SBN.CHC1.H.07.CO.BSC |
| HMO Basic Limited Mandate Health Benefit Plan for Colorado – Pharmacy Rider | RDR.RX.NET.H.07.CO.BSC |
| HMO Limited Mandate Health Benefit Plan for Colorado – Pharmacy Schedule of Benefits | RDR.RXSBN1.NET.H.07.CO.BSC |

2009 Standard Health Benefit Plan (Group Forms), 118 Members

| Form Name | Form Number |
|---|---|
| HMO Standard Health Benefit Plan for Colorado – Certificate | StdChc.COC.H.07.CO |
| MCE 2009 amendment – Standard HMO SB COC | MCE09STDHMOSB.AMD.H.07.CO |
| MCE 2009 Correction – Standard HMO SB Medical SOB | SBN.CHC1.H.07.CO.STD |
| SBN-Medical-HMO-2007-Choice Standard-SB-Rev1 | SBN.CHC1.H.07.CO.STD |
| HMO Standard Health Benefit Plan for Colorado – Pharmacy Rider | RDR.RX.NET.H.07.CO.STD |
| HMO Standard Health Benefit Plan for Colorado – Pharmacy Schedule of Benefits | RDR.RXSBN1.NET.H.07.CO.STD |

2009 Basic Health Benefit Plan (Conversion Forms), one (1) Member

| **Form Name** | **Form Number** |
|---|---|
| HMO Basic Limited Mandate Health Benefit Plan for Colorado – Conversion Policy | PolicyBasConv6109.H.07.CO |
| HMO Basic Limited Mandate Health Benefit Plan for Colorado – Conversion Medical Schedule of Benefits | SBN.CHC1.H.07.CO.HMOBSCCONV6109 |
| HMO Basic Limited Mandate Health Benefit Plan for Colorado – Conversion Pharmacy Rider | RDR.RX.NET.H.07.CO.HMOBSCCONV6109 |
| HMO Basic Limited Mandate Health Benefit Plan for Colorado – Conversion Pharmacy Schedule of Benefits | RDR.RXSBN1.NET.H.07.CO.HMOBSCCONV6109 |
| MCE 2009 Amendment – Basic HMO Conversion Policy | MCE09BSCHMOCONV.AMD.H.07.CO |
| MCE 2009 Correction – Basic HMO Conversion Medical SOB | SBN.CHC1.H.07.CO.HMOBSCCONV6109 |
| MCE 2009 Amendment (Sept) – Basic and Standard HMO Conversion Policy | MCE09BSCSTDHMOCONVSEPT.AMD.H.07.CO |

2009 Standard Health Benefit Plan (Conversion Forms), two (2) Members

| **Form Name** | **Form Number** |
|---|---|
| HMO Standard Health Benefit Plan for Colorado – Conversion Policy | PolicyStdConv6109.H.07.CO |
| HMO Standard Health Benefit Plan for Colorado – Conversion Medical Schedule of Benefits | SBN.CHC1.H.07.CO.HMOSTDCONV6109 |
| HMO Standard Health Benefit Plan for Colorado – Conversion Pharmacy Rider | RDR.RX.NET.H.07.CO.HMOSTDCONV6109 |
| HMO Standard Health Benefit Plan for Colorado – Conversion Pharmacy Schedule of Benefits | RDR.RXSBN1.NET.H.07.CO.HMOSTDCONV6109 |
| MCE 2009 Amendment – Standard HMO Conversion Policy | MCE09STDHMOCONV.AMD.H.07.CO |
| MCE 2009 Correction – Standard HMO Conversion Medical SOB | SBN.CHC1.H.07.CO.HMOSTDCONV6109 |

2009 – 2001 Series (Group Forms), ninety-seven (97) Members & Series renewing on or after 10/3/09, eighteen (18) Members

| **Form Name** | **Form Number** |
|---|---|
| Group Policy | POLICYH.01.CO |
| Group Policy Amendment 2004 | POLAMD.H.02.CO(12-2003) |
| 2004 Choice Certificate of Coverage | CHOICECO.01 (12-2003) |
| Choice COC Amendment | CHCAMD.H.02.CO |
| 4 Tier Outpatient RX Rider – Network Only | RXNET4TIER.H.04.CO |
| Reconstructive Procedures Benefit Amendment – Large & Small Group – HMO | RPAMD.CMS.H.01.CO |
| HMO Small Group/Key Accounts Schedule of Benefits Amendment | Mandated Benefits.H.01.CO |
| Hearing Aid Rider 2001 Series HMO | 1109HEARINGAID.AMD.H.01.CO |
| 7/1/09 Colorectal Cancer Screening COC Amendment – 2001 Series HMO | CLORECTAL.AMD.H.01.CO |

| | |
|---|---|
| Clinical Trials Amendment – 2001 Series | CLINICALTRIALSAMD.H.01.CO |
| MCE 2009 Amendment – Choice/Select (HMO) – 2001 Series | MCE09AMD.H.01.CO |

HEALTH BENEFIT PLAN DESCRIPTION FORMS

**Description Form Names**
United Healthcare Choice Plan LOC
Basic HMO Choice Plan JDJ
Standard HMO Choice Plan JDJ
LBA/PSB1 UnitedHealthcare Choice Plus HMO $10 office visit, 90/70 Plan
LBB/PSB2 UnitedHealthcare Choice Plus HMO $15 office visit, 90/60 Plan
LBC/PSB5 UnitedHealthcare Choice Plus HMO $15 office visit, 80/60 Plan
LBD/PSB7 UnitedHealthcare Choice Plus HMO $20 office visit, $300 ded. 80/60 Plan
LBE/PSB8 UnitedHealthcare Choice Plus HMO $20 office visit, $750 ded. 80/60 Plan

APPLICATIONS

| **Form Name** | **Form Number** |
|---|---|
| Employer Application for Small Business | 380-5241 CO ER app |
| Application for Conversion from Group Medical Coverage | GCAPP101COREV1-10 |

## EXAMINATION REPORT SUMMARY

The examination resulted in a total of seventeen (17) findings in which the Company did not appear to be in compliance with Colorado statutes and regulations. The following is a summary of the examiners' findings.

**Company Operations and Management:** The examiners identified one (1) area of concern in their review of Company Operations and Management.

**Issue A1: Failure to reflect in its Access Plan that referrals approved by the plan cannot be changed after preauthorization is provided unless there is evidence of fraud or abuse.**

**Contract Forms:** The examiners identified sixteen (16) areas of concern in their review of the Company's contract forms (including evidence of coverage forms, employer/employee applications, health plan description forms and riders/amendments/endorsements):

**Issue E1: Failure to correctly reflect the mandatory coverage provisions for newborn children born with cleft lip and/or cleft palate or both.**

**Issue E2: Failure to provide coverage for the repair and replacement of prosthetic devices, unless such failure is necessitated by misuse or loss and/or including benefit information that is more limiting than the mandatory coverage provisions.**

**Issue E3: Failure to reflect complete or correct benefit descriptions for mandated mental health services.**

**Issue E4: Failure to specify the period to be used for mammography coverage.**

**Issue E5: Failure to reflect all required benefits for Home Health Services and Hospice Care.**

**Issue E6: Failure to reflect completely the situations in which non-emergency care delivered in an emergency room would be covered.**

**Issue E7: Failure to reflect the mandated minimum hours of hospital stay to be provided for normal and cesarean section deliveries.**

**Issue E8: Failure to reflect accurate requirements to qualify as dependent.**

**Issue E9: Failure to reflect a complete description of mandatory coverage for child health supervision services.**

**Issue E10: Failure to reflect correct procedures for adding benefits, making changes, modifications or withdrawals with amendments to the Basic and Standard Health Benefit plans.**

**Issue E11: Failure to include a disclosure regarding the mechanisms to obtain the carrier's reimbursement rates to nonparticipating providers.**

**Issue E12: Failure to reflect the correct format and/or benefits in the Basic and Standard Health Benefit Plan Description Forms.**

**Issue E13: Failure to reflect that coverage is provided for the full cost of cervical cancer vaccination for all females for whom a vaccination is recommended.**

**Issue E14: Failure to reflect the correct percentage payable by the Company for durable medical equipment under the basic and standard health benefit plans.**

**Issue E15: Failure to reflect the correct percentage payable by the Company for prosthetic devices.**

**Issue E16: Failure to reflect benefits and exclusions pertaining to clinical trials that are consistent with mandatory coverage provisions.**

# MARKET CONDUCT EXAMINATION REPORT

# FACTUAL FINDINGS

# COMPANY OPERATIONS AND MANAGEMENT

**Issue A1: Failure to reflect in its Access Plan that referrals approved by the plan cannot be changed after preauthorization is provided unless there is evidence of fraud or abuse.**

Section 10-16-704, C.R.S., Network Adequacy – rules – legislative declaration – repeal, states in part:

> . . .
>
> (9) Beginning January 1, 1998, a carrier shall maintain and make available . . . an access plan for each managed care network that the carrier offers in this state. The access plan of a carrier offering a managed care plan shall demonstrate the following:
>
> . . .
>
> (b) A carrier offering a managed care plan shall maintain procedures for making referrals within and outside its network that, at a minimum, must include the following:
>
> . . .
>
> (V)(A). A provision that referrals approved by the plan cannot be retrospectively denied except for fraud or abuse.
>
> (B) *A provision that referrals approved by the plan cannot be changed after the preauthorization is provided unless there is evidence of fraud or abuse.* [Emphasis added.]

It appears that the Company is not in compliance with Colorado Insurance law as the 2009 Access Plan does not include the provision that referrals approved by the plan cannot be changed after the preauthorization is provided unless there is evidence of fraud or abuse. The 2009 Access Plan includes the following:

> Getting Needed Specialty Care
>
> All UnitedHealthcare MEMBERS
>
> Prior notification for Certain Services
>
> Certain services require notification and/or approval in advance of your receiving services. Your network doctor will be responsible for the notification and/or approval to UnitedHealthcare. UnitedHealthcare will not deny coverage for services previously approved except for fraud or abuse.

Form: UnitedHealthcare of Colorado, Inc. (UnitedHealthcare) Access Plan: Ensuring You Get the Care You Need October 2009
Form Number: UHCCO458996-000

**Recommendation No. 1:**

No later than thirty (30) days from the date this report is adopted, the Company should provide documentation demonstrating why it should not be considered in violation of §10-16-704, C.R.S. In the event the Company is unable to show such proof, it should provide written evidence to the Division that it has revised its access plan to reflect that referrals approved by the plan cannot be changed after preauthorization is provided unless there is evidence of fraud or abuse, as is mandated by Colorado insurance law.

# CONTRACT FORMS

**Issue E1: Failure to correctly reflect the mandatory coverage provisions for newborn children born with cleft lip and/or cleft palate or both.**

Section 10-16-104, C.R.S., Mandatory coverage provisions, states:

(1) Newborn children

. . .

(c) (II) (A) With regard to newborn children born with cleft lip or cleft palate or both, *there shall be no age limit on benefits for such conditions, and care and treatment shall include* to the extent medically necessary: *Oral and facial surgery,* surgical management, and follow-up care by plastic surgeons and oral surgeons; prosthetic treatment such as obturators, speech appliances, and feeding appliances; *medically necessary orthodontic treatment; medically necessary prosthodontic treatment;* habilitative speech therapy; otolaryngology treatment; and audiological assessments and treatment. [Emphases added.]

. . .

(C) If a dental insurance policy, a contract for dental insurance, or an enrollee coverage contract issued pursuant to this article is in effect at the time of the birth, or is purchased after the birth, of a child with cleft lip or cleft palate or both, it shall provide fully for any orthodontics or dental care needed as a result of the cleft lip or cleft palate or both. Such policy or contract may contain the same copayment provisions for the coverage of cleft lip or cleft palate or both as apply to other conditions or procedures covered by the policy or contract.

It appears that the Company is not in compliance with Colorado insurance law in that the description in Section 1: What's Covered – Benefits indicates that these benefits are provided only for an Enrolled Dependent Child.

Additionally, in Section 1: What's Covered – Benefits, the description of benefits in connection with cleft lip and/or cleft palate states that these benefits are provided **only** for a child who does not have a dental insurance policy or plan in effect at the time the services below are received. Colorado insurance law requires that an existing dental insurance policy or plan in effect at the time services are provided is only to provide fully for any orthodontics or dental care needed as a result of the cleft lip or cleft palate or both. The treatments for cleft lip and/or cleft palate or both, include other medically necessary care services that do not appear to be orthodontic or dental care in nature and would have to be covered by this plan.

The Company's 2004 Choice Certificate of Coverage, form number CHOICECO.01 (12-2003), applicable to policies issued in the 2009 – 2001 Series Group, states on page 8:

4. Cleft Lip and Cleft Palate Treatment

Benefits for the following services provided to an Enrolled Dependent child in connection with cleft lip and/or cleft palate when provided by or under the direction of a Physician. These Benefits are provided only for an Enrolled Dependent child who does

not have a dental insurance policy or plan in effect at the time the services below are received.

- Orthodontic services.
- Oral and facial surgery.
- Habilitative speech therapy.
- Prosthetic devices such as obturators, speech appliances, and feeding appliances.
- Otolaryngological services.
- Surgical management.
- Follow-up care by plastic surgeons or oral surgeons.
- Audiological services.
- Prosthodontic services.

The Company's HMO Basic Limited Mandate Health Benefit Plan for Colorado – Certificate, form number BasChcCOC.H.07.CO, states on page 17:

[25.] Cleft Lip and Cleft Palate Treatment

The following services when provided by or under the direction of a Physician to an Enrolled Dependent child in connection with cleft lip and/or cleft palate:

- Orthodontic services.
- Oral and facial surgery.
- Habilitative speech therapy.
- Prosthetic devices such as obturators, speech appliances and feeding appliances.
- Otolaryngological services.
- Surgical management.
- Follow-up care by plastic surgeons or oral surgeons.
- Audiological services.
- Prosthodontic services.

Benefits are provided only for an Enrolled Dependent child who does not have a dental insurance policy or plan in effect at the time the services are received.

The Company's HMO Standard Health Benefit Plan for Colorado – Certificate, form number StdChcCOC.H.07.CO, states on page 19:

[30.] Cleft Lip and Cleft Palate Treatment

The following services when provided by or under the direction of a Physician to an Enrolled Dependent child in connection with cleft lip and/or cleft palate:

- Orthodontic services.
- Oral and facial surgery.
- Habilitative speech therapy.
- Prosthetic devices such as obturators, speech appliances and feeding appliances.
- Otolaryngological services.
- Surgical management.

- Follow-up care by plastic surgeons or oral surgeons.
- Audiological services.
- Prosthodontic services.

Benefits are provided only for an Enrolled Dependent child who does not have a dental insurance policy or plan in effect at the time the services are received.

The Company's HMO Basic Limited Mandate Health Benefit Plan for Colorado – Conversion policy, form number PolicyBasConv6109.H.07.CO, states on page 17:

[26.] Cleft Lip and Cleft Palate Treatment

The following services when provided by or under the direction of a Physician to an Enrolled Dependent child in connection with cleft lip and/or cleft palate:

- Orthodontic services.
- Oral and facial surgery.
- Habilitative speech therapy.
- Prosthetic devices such as obturators, speech appliances and feeding appliances.
- Otolaryngological services.
- Surgical management.
- Follow-up care by plastic surgeons or oral surgeons.
- Audiological services.
- Prosthodontic services.

Benefits are provided only for an Enrolled Dependent child who does not have a dental insurance policy or plan in effect at the time the services are received.

The Company's HMO Standard Health Benefit Plan for Colorado – Conversion policy, form number PolicyStdConv6109.H.07.CO, states on page 19:

[31.] Cleft Lip and Cleft Palate Treatment

The following services when provided by or under the direction of a Physician to an Enrolled Dependent child in connection with cleft lip and/or cleft palate:

- Orthodontic services.
- Oral and facial surgery.
- Habilitative speech therapy.
- Prosthetic devices such as obturators, speech appliances and feeding appliances.
- Otolaryngological services.
- Surgical management.
- Follow-up care by plastic surgeons or oral surgeons.
- Audiological services.
- Prosthodontic services.

Benefits are provided only for an Enrolled Dependent child who does not have a dental insurance policy or plan in effect at the time the services are received.

**Forms amended effective August 21, 2009.** The Company's amended forms as listed below do not appear to include changes that are sufficient to meet the requirements of Colorado insurance law for the following reason:

MCE 2009 Amendment – Basic HMO SB COC, form number MCE09BSCHMOSB.AMD.H.07.CO,

MCE 2009 Amendment – Standard HMO SB COC, form number MCE09STDHMOSB.AMD.H.07.CO,

MCE 2009 Amendment – Basic HMO Conversion Policy, form number MCE09BSCHMOCONV.AMD.H.07.CO,

MCE 2009 Amendment – Standard HMO Conv. Policy, form number MCE09STDHMOCONV.AMD.H.07.CO, and

MCE 2009 Amendment – Choice/Select (HMO) – 2001Series, form number MCE09AMD.H.01.CO

With regard to situations in which a dental insurance policy or plan is in effect in addition to the health plan, the forms now state that *no benefits* for orthodontics or dental care needed as a result of cleft lip or cleft palate, *will be provided if* a dental insurance policy is in effect at the time of the birth or is purchased after the birth of a child with cleft lip or cleft palate. [Emphasis added.] Although Colorado insurance law requires a dental plan to "fully cover" any orthodontics or dental care needed for treatment of cleft lip and/or cleft palate, it still requires coverage for orthodontics and dental care as well as other medically necessary medical treatment under the medical benefits of the policy. In addition, the statute allows the dental plan to contain the same copayment provisions as apply to other conditions or procedures covered by the policy. Therefore, it would appear that benefits for orthodontics or dental care necessary for the treatment of a cleft lip and/or cleft palate should only be excluded to the extent that they are covered by a dental insurance policy or plan in effect at the time of treatment.

The amended documents include the following:

Cleft Lip and Cleft Palate Treatment

The following services when provided by or under the direction of a Physician in connection with cleft lip and/or cleft palate:

- Orthodontic services.
- Oral and facial surgery.
- Habilitative speech therapy.
- Prosthetic devices such as obturators, speech appliances, and feeding appliances.
- Otolaryngological services.
- Surgical management.
- Follow-up care by plastic surgeons or oral surgeons.
- Audiological services.
- Prosthodontic services.

If a dental insurance policy is in effect at the time of the birth, or is purchased after the birth of a child with cleft lip or cleft palate or both, no benefits will be provided for any orthodontics or dental care needed as a result of the cleft lip or cleft palate or both.

| **Forms** | **Form Numbers** |
|---|---|
| Choice Certificate of Coverage | CHOICECO.01 (12-2003) |
| HMO Basic Limited Mandate Health Benefit Plan for Colorado – Certificate | BasChcCOC.H.07.CO |
| HMO Standard Health Benefit Plan for Colorado – Certificate | StdChcCOC.H.07.CO |
| HMO Basic Limited Mandate Health Benefit Plan for Colorado – Conversion policy | PolicyBasConv6109.H.07.CO |
| HMO Standard Health Benefit Plan for Colorado – Conversion policy | PolicyStdConv6109.H.07.CO |

| **Amended Forms** | **Amended Form Numbers** |
|---|---|
| MCE 2009 Amendment – Basic HMO SB COC | MCE09BSCHMOSB.AMD.H.07.CO |
| MCE 2009 Amendment – Standard HMO SB COC | MCE09STDHMOSB.AMD.H.07.CO |
| MCE 2009 Amendment – Basic HMO Conversion Policy | MCE09BSCHMOCONV.AMD.H.07.CO |
| MCE 2009 Amendment – Standard HMO Conv. Policy | MCE09STDHMOCONV.AMD.H.07.CO |
| MCE 2009 Amendment – Choice/Select (HMO) – 2001Series | MCE09AMD.H.01.CO |

**Recommendation No. 2:**

No later than thirty (30) days from the date this report is adopted, the Company should provide documentation demonstrating why it should not be considered in violation of §10-16-104, C.R.S. In the event the Company is unable to show such proof, it should provide written evidence to the Division that it has implemented procedures to ensure that its forms reflect the mandated coverage to be provided for the treatment of cleft lip and/or cleft palate as is mandated by Colorado insurance law.

**Issue E2: Failure to provide coverage for the repair and replacement of prosthetic devices, unless such failure is necessitated by misuse or loss and/or including benefit information that is more limiting than the mandatory coverage provisions.**

Section 10-16-104, C.R.S., Mandatory coverage provisions, states in part:

> (14) Prosthetic devices
>
> (a) Any health benefit plan, except supplemental policies covering a specified disease or other limited benefit, that provides hospital, surgical, or medical expense insurance shall provide coverage for benefits for prosthetic devices that equal those benefits provided for under federal laws for health insurance for the aged and disabled pursuant to 42 U.S.C. secs. 1395k, and 13951, and 1395m and 42 CFR 414.202, 414.210. 414.228 and 410.100, as applicable to this subsection (14).
>
> (b) For the purposes of this subsection (14) "prosthetic device" means an artificial device to replace, in whole or in part, an arm or leg.
>
> …
>
> (e) *Repairs and replacements of prosthetic devices are also covered*, subject to copayments and deductibles, *unless necessitated by misuse or loss*. [Emphasis added.]

It appears that the Company is not in compliance with Colorado insurance law in that its forms either do not include coverage for repairs or replacements of prosthetic devices, or include benefit information that appears to be more limiting than the mandatory coverage.

The Company's HMO Small Group/Key Accounts Schedule of Benefits Amendment, form number MandatedBenefits.H.01.CO, applicable to the 2009 – 2001 Series Group forms, as shown below, does not include a provision for repairs and replacements of prosthetic devices:

> Prosthetic Devices
>
> Prosthetic devices that replace a limb or body part including:
>
> - Artificial limbs.
> - Artificial eyes.
> - Breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998.
> - Prosthetic arms and legs are based on criteria that will be covered in accordance with Medicare guidelines and criteria and are not subject to the Durable Medical Equipment maximum. Bionic, myoelectric, microprocessor-controlled and computerized prosthetics are covered in accordance with Medicare guidelines and criteria.
>
> If more than one prosthetic device can meet your functional needs, Benefits are available only for the most cost-effective prosthetic device.

Group [text] [1]Include when group chooses a plan with a Prosthetic purchase every two or more years. The standard is once every three years.

| | |
|---|---|
| Group [text] | [2]Include when group chooses a plan with a Prosthetic purchase of once every year. |

The prosthetic device must be ordered or provided by, or under the direction of a Physician. Benefits for prosthetic devices are limited to a single purchase of each type of prosthetic device every [[1]two-five] [calendar][Policy] [[1]years][[2]year].

| | |
|---|---|
| Group [Para] | Include when group chooses to limit the benefit. |
| Group [text] | [1]Insert benefit limit selected by group. Standard options are $2,500 and $5,000. |

- **[**Benefits for prosthetic devices are limited to [[1]$2,500-$10,000] per [calendar][Policy] year. This limit does not apply to prosthetic arms and legs.**]**

The Company's HMO Basic Limited Mandate Health Benefit Plan for Colorado – Certificate, form number BasChcCOC.H.07.CO, states on page 13:

[15.] Prosthetic Devices

External prosthetic devices that replace a limb or a body part, limited to:

- Prosthetic arms and legs is based on criteria that will be covered in accordance with Medicare guidelines and criteria and is not subject to the Durable Medical Equipment maximum. Bionic, myoelectric, microprocessor-controlled and computerized prosthetics are covered in accordance with Medicare guidelines and criteria.
- Artificial face, eyes, ears and noses.
- Speech aid prosthetics and tracheo-esophageal voice prosthetics.
- Breast prosthesis as required by the *Women's Health and Cancer Rights Act of 1998*. Benefits include mastectomy bras and lymphedema stockings for the arm.

Benefits under this section are provided only for external prosthetic devices and do not include any device that is fully implanted into the body other than breast prostheses. If more than one prosthetic device can meet your functional needs, Benefits are available only for the prosthetic device that meets the minimum specifications for your needs. If you purchase a prosthetic device that exceeds these minimum specifications, we will pay only the amount that we would have paid for the prosthetic that meets the minimum specifications, and you will be responsible for paying any difference in cost.

The prosthetic device must be ordered or provided by, or under the direction of a Physician.

Benefits are available for repairs and replacement, except that:

- There are no Benefits for repairs due to misuse, malicious damage or gross neglect.
- *There are no Benefits for replacement due to* misuse, malicious damage, gross neglect or for lost or *stolen prosthetic devices.* [Emphasis added.]

The Company's HMO Standard Health Benefit Plan for Colorado – Certificate, form number StdChcCOC.H.07.CO, states on page 14:

[17.] Prosthetic Devices

External prosthetic devices that replace a limb or a body part, limited to:

- Prosthetic arms and legs is based on criteria that will be covered in accordance with Medicare guidelines and criteria and is not subject to the Durable Medical Equipment maximum. Bionic, myoelectric, microprocessor-controlled and computerized prosthetics are covered in accordance with Medicare guidelines and criteria.
- Artificial face, eyes, ears and noses.
- Speech aid prosthetics and tracheo-esophageal voice prosthetics.
- Breast prosthesis as required by the *Women's Health and Cancer Rights Act of 1998*. Benefits include mastectomy bras and lymphedema stockings for the arm.

Benefits under this section are provided only for external prosthetic devices and do not include any device that is fully implanted into the body other than breast prostheses. If more than one prosthetic device can meet your functional needs, Benefits are available only for the prosthetic device that meets the minimum specifications for your needs. If you purchase a prosthetic device that exceeds these minimum specifications, we will pay only the amount that we would have paid for the prosthetic that meets the minimum specifications, and you will be responsible for paying any difference in cost.

The prosthetic device must be ordered or provided by, or under the direction of a Physician.

Benefits are available for repairs and replacement, except that:

- There are no Benefits for repairs due to misuse, malicious damage or gross neglect.
- *There are no Benefits for replacement due to* misuse, malicious damage, gross neglect or for lost or *stolen prosthetic devices.* [Emphasis added.]

The Company's HMO Basic Limited Mandate Health Benefit Plan for Colorado – Conversion policy, form number PolicyBasConv6109.H.07.CO, states on page 13:

[16.] Prosthetic Devices

External prosthetic devices that replace a limb or a body part, limited to:

- Prosthetic arms and legs are based on criteria that will be covered in accordance with Medicare guidelines and criteria and are not subject to the Durable Medical Equipment maximum. Bionic, myoelectric, microprocessor-controlled and computerized prosthetics are covered in accordance with Medicare guidelines and criteria.
- Artificial face, eyes, ears and noses.
- Speech aid prosthetics and tracheo-esophageal voice prosthetics.
- Breast prosthesis as required by the *Women's Health and Cancer Rights Act of 1998*. Benefits include mastectomy bras and lymphedema stockings for the arm.

Benefits under this section are provided only for external prosthetic devices and do not include any device that is fully implanted into the body other than breast prostheses. If more than one prosthetic device can meet your functional needs, Benefits are available only for the prosthetic device that meets the minimum specifications for your needs. If you purchase a prosthetic device that exceeds these minimum specifications, we will pay only the amount that we would have paid for the prosthetic that meets the minimum specifications, and you will be responsible for paying any difference in cost.

The prosthetic device must be ordered or provided by, or under the direction of a Physician.

Benefits are available for repairs and replacement, except that:

- There are no Benefits for repairs due to misuse, malicious damage or gross neglect.
- *There are no Benefits for replacement due to* misuse, malicious damage, gross neglect or for lost or *stolen prosthetic devices*. [Emphasis added.]

The Company's HMO Standard Health Benefit Plan for Colorado – Conversion policy, form number PolicyStdConv6109.H.07.CO, states on page 14:

[18.] Prosthetic Devices

External prosthetic devices that replace a limb or a body part, limited to:

- Prosthetic arms and legs are based on criteria that will be covered in accordance with Medicare guidelines and criteria and are not subject to the Durable Medical Equipment maximum. Bionic, myoelectric, microprocessor-controlled and computerized prosthetics are covered in accordance with Medicare guidelines and criteria.
- Artificial face, eyes, ears and noses.
- Speech aid prosthetics and tracheo-esophageal voice prosthetics.
- Breast prosthesis as required by the *Women's Health and Cancer Rights Act of 1998*. Benefits include mastectomy bras and lymphedema stockings for the arm.

Benefits under this section are provided only for external prosthetic devices and do not include any device that is fully implanted into the body other than breast prostheses. If more than one prosthetic device can meet your functional needs, Benefits are available only for the prosthetic device that meets the minimum specifications for your needs. If you purchase a prosthetic device that exceeds these minimum specifications, we will pay only the amount that we would have paid for the prosthetic that meets the minimum specifications, and you will be responsible for paying any difference in cost.

The prosthetic device must be ordered or provided by, or under the direction of a Physician.

Benefits are available for repairs and replacement, except that:

- There are no Benefits for repairs due to misuse, malicious damage or gross neglect.

- *There are no Benefits for replacement due to* misuse, malicious damage, gross neglect or for lost or *stolen prosthetic devices.* [Emphasis added.]

**Forms amended effective August 21, 2009.** The Company's amended forms include a more restrictive requirement for repair and replacement of prosthetic devices. The documents include the following under the Description of Covered Health Service:

The Company's MCE 2009 Amendment – Choice/Select (HMO) – 2001 Series, form number MCE09AMD.H.01.CO, applicable to policies issued in the 2009 – 2001 Series Group, states in part:

> Prosthetic Devices
>
> Prosthetic devices that replace a limb or body part including:
>
> - Artificial limbs.
> - Artificial eyes.
> - Breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998. Benefits include mastectomy bras and lymphedema stockings for the arm.
> - Prosthetic arms and legs are based on criteria that will be covered in accordance with Medicare guidelines and criteria[1] and are not subject to the Durable Medical Equipment Benefit limits]. Bionic, myoelectric, microprocessor-controlled and computerized prosthetics are covered in accordance with Medicare guidelines and criteria. Benefits are available for repairs and replacement, except that: 1) There are no Benefits for repairs due to misuse, malicious damage or gross neglect and 2) *There are no Benefits for replacement due to* misuse, malicious damage or gross neglect or for lost or *stolen prosthetic devices*. [Emphasis added.]

Other amended forms as noted below include the following:

> MCE 2009 Amendment – Basic HMO SB COC, form number MCE09BSCHMOSB.AMD.H.07.CO,
>
> MCE 2009 Amendment – Standard HMO SB COC, form number MCE09STDHMOSB.AMD.H.07.CO,
>
> MCE 2009 Amendment – Basic HMO Conv. Policy, form number MCE09BSCHMOCONV.AMD.H.07.CO, and
>
> MCE 2009 Amendment – Standard HMO Conv. Policy, form number MCE09STDHMOCONV.AMD.H.07.CO
>
> Prosthetic Devices
>
> External prosthetic devices that replace a limb or a body part, limited to:
>
> - Prosthetic arms and legs are based on criteria that will be covered in accordance with Medicare guidelines and criteria and are not subject to the Durable Medical Equipment Benefit limits. Bionic, myoelectric, microprocessor-controlled and computerized prosthetics are covered in

accordance with Medicare guidelines and criteria. Benefits are available for repairs and replacement, except that: 1) There are no Benefits for repairs due to misuse, malicious damage or gross neglect and 2) There are no Benefits for replacement due to misuse, malicious damage or gross neglect or for lost or stolen prosthetic devices.

- Artificial face, eyes, ears and noses.
- Speech aid prosthetics and tracheo-esophageal voice prosthetics.
- Breast prosthesis as required by the *Women's Health and Cancer Rights Act of 1998*. Benefits include mastectomy bras and lymphedema stockings for the arm.

Benefits under this section are provided only for external prosthetic devices and do not include any device that is fully implanted into the body other than breast prostheses.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the prosthetic device that meets the minimum specifications for your needs. If you purchase a prosthetic device that exceeds these minimum specifications, we will pay only the amount that we would have paid for the prosthetic that meets the minimum specifications, and you will be responsible for paying any difference in cost.

The prosthetic device must be ordered or provided by, or under the direction of a Physician.

Benefits are available for repairs and replacement, except that:

- There are no Benefits for repairs due to misuse, malicious damage or gross neglect.
- *There are no Benefits for replacement due to* misuse, malicious damage, gross neglect or fo*r* lost or *stolen prosthetic devices.* [Emphasis added.]

| **Forms** | **Form Numbers** |
|---|---|
| HMO Small Group/Key Accounts Schedule of Benefits Amendment | MandatedBenefits.H.01.CO |
| HMO Basic Limited Mandate Health Benefit Plan for Colorado – Certificate | BasChcCOC.H.07.CO |
| HMO Basic Limited Mandate Health Benefit Plan for Colorado – Certificate | StdChcCOC.H.07.CO |
| HMO Basic Limited Mandate Health Benefit Plan for Colorado – Conversion Policy | PolicyBasConv6109.H.07.CO |
| HMO Standard Health Benefit Plan for Colorado – Conversion policy | PolicyStdConv6109.H.07.CO |

| **Amended Forms** | **Amended Form Numbers** |
|---|---|
| MCE 2009 Amendment – Choice/Select (HMO) – 2001 Series | MCE09AMD.H.01.CO |
| MCE 2009 Amendment – Basic HMO SB COC | MCE09BSCHMOSB.AMD.H.07.CO |
| MCE 2009 Amendment – Standard HMO SB COC | MCE09STDHMOSB.AMD.H.07.CO |
| MCE 2009 Amendment – Basic HMO Conv. Policy | MCE09BSCHMOCONV.AMD.H.07.CO |
| MCE 2009 Amendment – Standard HMO Conv. Policy | MCE09STDHMOCONV.AMD.H.07.CO |

**Recommendation No. 3:**

No later than thirty (30) days from the date this report is adopted, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-104, C.R.S. In the event the Company is unable to show such proof, it should provide written evidence to the Division that it has implemented procedures to ensure that its forms reflect the mandated coverage for prosthetic devices, including repair and replacement unless necessitated by misuse or loss as is mandated by Colorado insurance law.

**Issue E3: Failure to reflect complete or correct benefit descriptions for mandated mental health services.**

Section 10-16-104 C.R.S., Mandatory coverage provisions – definitions states in part:

. . .

(5) Mental illness: Every small group policy providing hospitalization or medical benefits by an entity subject to the provisions of part 2 or 3 of this article shall provide benefits for conditions arising from mental illness at least equal to the following:

(a) In the case of basic coverage benefits based upon either confinement as an inpatient or partial hospitalization in a hospital or psychiatric hospital licensed by the department of public health and environment, *the period of confinement for which benefits are payable shall be at least forty-five days for inpatient care or ninety days for partial hospitalization in any one twelve-month-benefit period.* For the purpose of computing the period for which benefits are payable, *each two days of partial hospitalization care shall reduce by one day the forty-five days available for inpatient care, and each day of inpatient care shall reduce by two days the ninety days available for partial hospitalization care. Each day of confinement as an inpatient or each two days of partial hospitalization shall reduce by one day the total days available for all other illnesses during any one twelve-month-benefit period. Each day of confinement as an inpatient in a hospital or psychiatric hospital or each two days of partial hospitalization shall reduce by one day the available days provided under subsection (9) of this section. For the purpose of this subsection (5), "partial hospitalization" means continuous treatment for at least three hours, but not more than twelve hours, in any twenty-four-hour period.* [Emphasis added.]

. . .

(g) Every group health care service plan providing hospitalization or medical benefits under the provisions of part 4 of this article shall provide benefits for conditions arising from mental illness at least equal to the benefits required by this subsection (5). The health care service plan issued by an entity subject to the provisions of part 4 of this article may provide that the benefits required pursuant to this subsection (5) shall be covered benefits only if the services are rendered by a provider who is designated by and affiliated with the health maintenance organization.

(This version of paragraph "g" is effective until July 1, 2009.)

(g) Every small group plan that is a health care service plan providing hospitalization or medical benefits under the provisions of part 4 of this article shall provide benefits for conditions arising from mental illness at least equal to the benefits required by this subsection (5). The health care service plan issued by an entity subject to the provisions of part 4 of this article may provide that the benefits required pursuant to this subsection (5) shall be covered benefits only if the services are rendered by a provider who is designated by and affiliated with the health maintenance organization.

(This version of paragraph "g" is effective July 1, 2009.)

. . .

(9) Availability of coverage for alcoholism.

(a) Any other provision of law to the contrary notwithstanding, no hospitalization or medical benefits contract on a group basis issued by an insurer subject to the provisions of part 2 of this article or an entity subject to the provisions of part 3 of this article shall be sold in this state unless the policyholder under such contract or persons holding the master contract under such contract are offered the opportunity to purchase coverage for the benefits for the treatment of and for conditions arising from alcoholism, which benefits are at least equal to the following minimum requirements:

I. In the case of benefits based upon confinement as an inpatient in an accredited or licensed hospital or in any other public or private facility or portion thereof providing services especially for the treatment of alcoholics, which is licensed by the department of human services for those services, *such benefits shall be not less than forty-five days in any calendar year*. [Emphasis added.]

II. Each day of confinement as an inpatient shall reduce by one day the total days available for all other illnesses during any one twelve-month-benefit period.

III. Each day of confinement as an inpatient shall reduce by one day the available days provided under subsection (5) of this section.

Emergency Regulation 08-E-12 (effective 1/1/09), Concerning Small Employer Group Health Benefit Plans and the Basic and Standard Health Benefit Plans, promulgated under the authority of §§ 10-1-109, 10-16-105 (7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states in part:

Section 2 Scope and Purpose

The purpose of this emergency regulation is to comply with the enactment of Senate Bill 08-057, which mandates coverage of hearing aids for children under the age of 18 and House Bill 08-1410, concerning the coverage of colorectal cancer prevention services. This emergency regulation specifies the requirements for the basic and standard health benefit plans as well as other requirements for small employer carriers.

. . .

Section 4 Rules

A. Plans

. . .

(2) Standard Plan. The form and content of the standard health benefit plan, as appended to this regulation, shall constitute the standard health benefit

plan required for use in Colorado's small employer group market pursuant to § 10-16-105(7.3), C.R.S., and for use as conversion coverage pursuant to §10-16-108, C.R.S.

BASIC AND STANDARD HEALTH BENEFIT PLAN POLICY REQUIREMENTS FOR THE STATE OF COLORADO

Colorado Division of Insurance

Effective January 1, 2009

. . .

(2) The standard health benefit plan for an indemnity, PPO, and HMO plan *shall include the specific benefits and coverages outlined in the attached table labeled* "Standard Health Benefit Plan". [Emphasis added.]

Benefit Grid

JANUARY 1, 2009 COLORADO STANDARD HEALTH BENEFIT PLANS: INDEMNITY, PPO, AND HMO

| | STANDARD HMO PLAN |
|---|---|
| | IN-NETWORK ONLY (Out-of-network care is not covered except as noted.) |
| 19. Other Mental Health Care [16]<br>a) Inpatient Care [17] | 50% copay<br>Maximum 45 inpatient or 90 partial days/year |
| b) Outpatient Care | 50% copay<br>Plans pay maximum 20 visits or $1,500/year |

Footnote 16: Pursuant to §10-16-105(1), C.R.S., the following small employers may exclude mental health coverage from their plans: any small employer who has not provided group sickness and accident insurance to employees after July 1, 1989, and any small employer who has provided group sickness and accident from a person or entity licensed pursuant to §10-3-903.5, C.R.S., that did not include mental health coverage after July 1, 1989. However, carriers allowing for such an exclusion must follow all the relevant provisions of §10-16-105(2), C.R.S., relating to such an exclusion.

Footnote 17: The day cost of residential care must be less than or equal to the cost of a partial day of hospitalization. Each two days of residential or partial hospital care counts as one day of inpatient care.

Colorado Insurance Regulation 4-6-5 (effective 2/1/09), Concerning Small Employer Group Health Benefit Plans and the Basic and Standard Health Benefit Plans, promulgated under the authority of §§ 10-1-109, 10-16-105 (7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states in part:

Section 2 Scope and Purpose

The purpose of the amendment to this regulation is to comply with Senate Bill 08-057, which mandates coverage of hearing aids for children under the age of 18 and house Bill 08-1410, concerning the coverage of colorectal cancer prevention services. *This regulation specifies the requirements for the basic and standard health benefit plans as well as other requirements for small employer carriers*. This regulation replaces Emergency Regulation 08-E-12 in its entirety. [Emphasis added.]

. . .

Section 4 Rules

A. Plans

. . .

2. Standard Plan. The form and content of the standard health benefit plan, as appended to this regulation, shall constitute the standard health benefit plan required for use in Colorado's small employer group market pursuant to § 10-16-105(7.3), C.R.S., and for use as conversion coverage pursuant to §10-16-108, C.R.S.

BASIC AND STANDARD HEALTH BENEFIT PLAN POLICY REQUIREMENTS FOR THE STATE OF COLORADO

Colorado Division of Insurance

Effective February 1, 2009

. . .

(2) The standard health benefit plan for an indemnity, PPO, and HMO plan *shall include the specific benefits and coverages outlined in the attached table labeled* "Standard Health Benefit Plan". [Emphasis added.]

Benefit Grid

FEBRUARY 1, 2009 COLORADO STANDARD HEALTH BENEFIT PLANS: INDEMNITY, PPO, AND HMO

| STANDARD HMO PLAN |
| --- |
| IN-NETWORK ONLY (Out-of-network care is not covered except as noted.) |

| | |
|---|---|
| 19. Other Mental Health Care [16]<br><br>a) Inpatient Care [17] | 50% copay<br>Maximum 45 inpatient or 90 partial days/year |
| b) Outpatient Care | 50% copay<br>Plans pay maximum 20 visits or $1,500/year |

Footnote 16: Pursuant to § 10-16-105(1), C.R.S., the following small employers may exclude mental health coverage from their plans: any small employer who has not provided group sickness and accident insurance to employees after July 1, 1989, and any small employer who has provided group sickness and accident from a person or entity licensed pursuant to § 10-3-903.5, C.R.S., that did not include mental health coverage after July 1, 1989. However, carriers allowing for such an exclusion must follow all the relevant provisions of § 10-16-105(2), C.R.S., relating to such an exclusion.

Footnote 17: The day cost of residential care must be less than or equal to the cost of a partial day of hospitalization. Each two days of residential or partial hospital care counts as one day of inpatient care.

The Company's forms, as noted below, do not appear to be in compliance with Colorado insurance law in that they do not reflect complete or correct benefit descriptions for Mental Health Services – Inpatient and Intermediate Care in the following ways:

The Company's HMO Small Group/Key Accounts Schedule of Benefit Amendment, form number MandatedBenefits.H.01.CO, applicable to policies issued in the 2009 -2001 Series Group, shown below, incorrectly states that the Company has discretion to determine whether or not two sessions of intermediate/partial hospitalization may be substituted for one inpatient day:

> Mental Health and Substance Abuse Services - Inpatient and Intermediate
>
> The Mental Health/Substance Abuse Designee, who will arrange for the services, will determine the appropriate setting for the treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis. *At the discretion of the Mental Health/Substance Abuse Designee,* two sessions of intermediate care (such as partial hospitalization) may be substituted for one inpatient day. [Emphasis added.]
>
> Group [Para] Include when group chooses to limit the benefit.
> [Benefits for Mental Health Services and/or Substance Abuse Services are limited to 45 days (or 90 partial days) per calendar year. Mental Health Services for the treatment of a Biologically Based Mental Illness are not subject to this limit.]

The Company's HMO Standard Health Benefit Plan for Colorado – Certificate, form number StdChcCOC.H.07.CO, as shown below, incorrectly states that the Mental Health Designee has discretion to determine if inpatient days may be converted to Intermediate Care or Transitional Care,:

> [11.] Mental Health Services - Inpatient and Intermediate

> Mental Health Services received on an inpatient or Intermediate Care basis in a Hospital or an Alternate Facility, including services to treat Biologically Based Mental Illnesses. Benefits include treatment of Mental Illness whether treatment is voluntary on the part of the Covered Person or court ordered as the result of contact with the criminal justice or legal system.
>
> The Mental Health Designee, who will authorize the services, will determine the appropriate setting for the treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis. When limits apply to inpatient or Intermediate Care services in the *Schedule of Benefits*, inpatient days may be converted to Intermediate Care (such as partial hospitalization or intensive outpatient programs) or Transitional Care *at the discretion of the Mental Health Designee*. [Emphasis added.]
>
> One Inpatient day is equivalent to:
>
> - Two sessions of partial hospitalization/residential day treatment.
> - Two sessions of partial hospitalization/day treatment.
>
> Mental Health Services must be provided by or under the direction of the Mental Health Designee. Referrals to a Mental Health Services provider are at the discretion of the Mental Health Designee, who is responsible for coordinating all of your care. Contact the Mental Health Designee regarding Benefits for Inpatient/Intermediate Mental Health Services.

The Company's HMO Standard Health Benefit Plan for Colorado – Conversion Policy, form number PolicyStdConv6109.H.07.CO, as shown below, incorrectly states that the Mental Health Designee has discretion to determine if inpatient days may be converted to Intermediate Care or Transitional Care:

> [12.] Mental Health Services - Inpatient and Intermediate
>
> Mental Health Services received on an inpatient or Intermediate Care basis in a Hospital or an Alternate Facility, including services to treat Biologically Based Mental Illnesses. Benefits include treatment of Mental Illness whether treatment is voluntary on the part of the Covered Person or court ordered as the result of contact with the criminal justice or legal system.
>
> The Mental Health Designee, who will authorize the services, will determine the appropriate setting for the treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis. When limits apply to inpatient or Intermediate Care services in the *Schedule of Benefits*, inpatient days may be converted to Intermediate Care (such as partial hospitalization or intensive outpatient programs) or Transitional Care *at the discretion of the Mental Health Designee.* [Emphasis added.]
>
> One Inpatient day is equivalent to:
>
> - Two sessions of partial hospitalization/residential day treatment.
> - Two sessions of partial hospitalization/day treatment.
>
> Mental Health Services must be provided by or under the direction of the Mental Health Designee. Referrals to a Mental Health Services provider are at the discretion of the Mental Health Designee, who is responsible for coordinating all of your care. Contact the

Mental Health Designee regarding Benefits for Inpatient/Intermediate Mental Health Services.

| **Forms** | **Form Numbers** |
|---|---|
| HMO Small Group/Key Accounts Schedule of Benefit Amendment | MandatedBenefits.H.01.CO |
| HMO Standard Health Benefit Plan for Colorado – Certificate | StdChcCOC.H.07.CO |
| HMO Standard Health Benefit Plan for Colorado – Conversion Policy | PolicyStdConv6109.H.07.CO |

**Recommendation No. 4:**

No later than thirty (30) days from the date this report is adopted, the Company should provide documentation demonstrating why it should not be considered in violation of §10-16-104, C.R.S., and Emergency Regulation 08-E-12 and Amended Colorado Insurance Regulation 4-6-5. In the event the Company is unable to show such proof, it should provide written evidence to the Division that it has revised all applicable forms to reflect complete and correct benefits for treatment of mental illness, in compliance with Colorado insurance law. The Division's records indicate that the Respondent has revised the language in the cited forms which, if fully implemented appears to comply with the corrective actions ordered concerning this violation. The statement is only applicable to the benefit descriptions for mandated mental health services, and nothing in this paragraph should be construed as approval of the language in the health benefit plans as a whole.

**Issue E4: Failure to specify the period to be used for mammography coverage.**

Section 10-16-104, C.R.S., Mandatory coverage provisions – definitions, states in part:

> . . .
>
> (4) Low-dose mammography
>
> (a) … Benefits for routine mammography screenings shall be determined on a calendar year or a contract year basis, *which shall be specified in the policy or contract*. … [Emphasis added.]
>
> (b) The requirements of this section shall apply to all individual sickness and accident insurance policies and health care service or indemnity contracts issued on or after July 1, 1995, and to all group accident and sickness policies and group health care service or indemnity contracts issued, renewed, or reinstated after July 1, 1995.

The description of benefits to be provided for mammography in the Company's certificates and forms listed below does not appear to be complete as required by Colorado insurance law in the following way:

- Nothing is reflected in the certificates to indicate whether annual screenings are to be provided on a calendar year or a contract year basis.

The Company's Choice COC Amendment, form number CHCAMD.H.02.CO, applicable to policies issued in the 2009 – 2001 Series Groups, states, in part, the following:

> *[*Physicians Office Services described in (Section 1: What's Covered--Benefits) is replaced with the following:*]*
>
> [Benefit Information]
>
> **[Physician's Office Services**
>
> Covered Health Services received in a Physician's office, including:
>
> - Mammography screening, including, but not limited to:
> - A baseline mammogram for women 35 through 39 years of age.
> - A mammogram every two years for women 40 through 49 years of age.
> - An annual mammogram (and clinical breast examination) for women 50 years of age or older.
> - An annual mammogram (and clinical breast examination) for women 40 years or older who have risk factors, as determined by a Network Physician.

The Company's HMO Standard Health Benefit Plan for Colorado – Certificate, form number StdChcCOC.H.07.CO, and HMO Standard Health Benefit Plan for Colorado – Conversion Policy, form number PolicyStdConv6109.H.07.CO, both state in part:

> [16.] Preventive Care Services

Services for preventive medical care provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital. Examples of preventive medical care are:
Lab, X-ray or other preventive tests:

- Mammography, including:
  - A baseline mammogram for women 35 through 39 years of age.
  - A mammogram every two years for women 40 through 49 years of age.
  - An annual mammogram for women 50 years of age or older.
  - An annual mammogram for women 40 years or older who have risk factors, as determined by a Physician.

**Forms amended effective August 21, 2009.** The Company's amended forms do not include changes that reflect the requirements of Colorado insurance law. The amended forms do not specify whether the benefits for routine mammography screenings are determined on a calendar year or a contract year basis. Instead, the forms direct the member to the Health Benefit Plan Description Forms, which are not considered a part of the policy contract.

The Company's amended form MCE 2009 Amendment – Choice/Select (HMO) – 2001 Series, form number MCE09AMD.H.01.CO, applicable to policies issued in the 2009 – 2001 Series Group, includes the following:

Physician's Office Services

Covered Health Services for preventive medical care.

Preventive medical care includes:

- Mammogram screenings, including:
- A baseline mammogram for women 35 through 39 years of age.
- A mammogram every two years for women 40 through 49 years of age.
- An annual mammogram (and clinical breast examination) for women 50 years of age or older.
- An annual mammogram (and clinical breast examination) for women 40 years or older who have risk factors, as determined by a Network Physician.
- *Please refer to your Colorado Health Benefit Plan Description Form to determine whether your Benefits are provided on a calendar year or policy year basis.* [Emphasis added.]

The Company's amended form MCE 2009 Amendment – Standard HMO SB COC, form number MCE09STDHMOSB.AMD.H.07.CO, states in part:

Preventive Care Services

Services for preventive medical care provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital. Examples of preventive medical care are:

Lab, X-ray or other preventive tests:

- Mammography, including:
  - A baseline mammogram for women 35 through 39 years of age.

- A mammogram every two years for women 40 through 49 years of age.
- An annual mammogram for women 50 years of age or older.
- An annual mammogram for women 40 years or older who have risk factors, as determined by a Physician.
- *Please refer to your Colorado Health Benefit Plan Description Form to determine whether your benefits are provided on a calendar year or policy year basis.* [Emphasis added.]

The Company's amended form MCE 2009 Amendment – Standard HMO Conversion Policy, form number MCE09STDHMOCONV.AMD.H.07.CO, states in part:

> Preventive Care Services
>
> Services for preventive medical care provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital. Examples of preventive medical care are:
>
> Lab, X-ray or other preventive tests:
>
> - Mammography, including:
> - A baseline mammogram for women 35 through 39 years of age.
> - A mammogram every two years for women 40 through 49 years of age.
> - An annual mammogram for women 50 years of age or older.
> - An annual mammogram for women 40 years or older who have risk factors, as determined by a Physician.
> - *Please refer to your Colorado Health Benefit Plan Description Form to determine whether your benefits are provided on a calendar year or policy year basis.* [Emphasis added.]

| **Forms** | **Form Numbers** |
|---|---|
| Choice COC Amendment | CHCAMD.H.02.CO |
| Standard Health Benefit Plan for Colorado – Certificate | StdChcCOC.H.07.CO |
| HMO Standard Health Benefit Plan for Colorado – Conversion Policy | PolicyStdConv6109.H.07.CO |

| **Amended Forms** | **Amended Form Numbers** |
|---|---|
| MCE 2009 Amendment – Choice/Select (HMO) – 2001 Series | MCE09AMD.H.01.CO |
| MCE 2009 Amendment – Standard HMO SB COC | MCE09STDHMOSB.AMD.H.07.CO |
| MCE 2009 Amendment – Standard HMO Conversion Policy | MCE09STDHMOCONV.AMD.H.07.CO |

**Recommendation No. 5:**

No later than thirty (30) days from the date this report is adopted, the Company should provide documentation demonstrating why it should not be considered in violation of §10-16-104, C.R.S. In the event the Company is unable to show such proof, it should provide written evidence to the Division that it has corrected all applicable forms to reflect a complete description of benefits to be provided for mammography as is mandated by Colorado insurance law.

**Issue E5: Failure to reflect all required benefits for Home Health Services and Hospice Care.**

Colorado Insurance Regulation 4-2-8, Concerning Required Health Insurance Benefits for Home Health Services and Hospice Care, promulgated under the authority of §§ 10-1-109 and 10-16-104(8)(d), C.R.S. states in part:

. . .

Section 4. Requirements for Home Health Care Services

. . .

C. Benefits for Home Health Services

(1) Benefits levels for home health care services shall not be less than the deductible, coinsurance and stop loss provisions of the overall policy or certificate.

(2) The policy or certificate may contain a limitation on the number of home health visits, but *no policy offered may provide for fewer than 60 home health visits in any calendar year.*

(3) The policy offered shall include benefits for the following services:

(a) Professional nursing services provided by a Registered Nurse;
(b) Certified nurse aide services under the supervision of a Registered Nurse or a qualified therapist;
(c) Physical therapy;
(d) Occupational therapy;
(e) Speech therapy and audiology;
(f) *Respiratory and inhalation therapy;*
(g) *Nutrition counseling by a nutritionist or dietitian;*
(h) Medical social services;
(i) Medical supplies;
(j) Prosthesis and orthopedic appliances;
(k) Rental or purchase of durable medical equipment; and
(l) Drugs, medicines, or insulin.

(4) The services identified in (C)(3)(i) through (C)(3)(l) above may be included elsewhere in the policy, rather than specifically in the home health benefit provisions.

Section 5. Requirements for Hospice Care

A. Definitions.

. . .

(18) A "benefit period" for hospice care services is a period of three months, during which services are provided on a regular basis.

(19) A "hospice per diem" rate is the predetermined rate for each day in which an individual is enrolled in a hospice program and under its care, without regard to which, if any, services are actually provided on a specific day.

. . .

C. Benefits for Hospice Care Services.

. . .

(2) The policy or certificate may contain a dollar limitation on routine home care hospice benefits. Other services provided by and through the hospice that are available to the insured will be negotiated at a hospice per diem rate with the hospice provider. *Any policy offered shall provide a benefit of no less than $100 per day for any combination of the following routine home care services, which are planned, implemented and evaluated by the interdisciplinary team:*

(a) Intermittent and 24 hour on-call professional nursing services provided by and under the supervision of a Registered Nurse.
(b) Intermittent and 24 hour on-call social/counseling services, and;
(c) Certified nurse aide services or nursing services delegated to other persons pursuant to § 12-38-132, C.R.S.

*The total benefit for each benefit period for these services shall not be less than the per diem benefit multiplied by ninety-one (91) days.* [Emphases added.]

(3) The policy offering shall include the following benefits, subject to the policy's deductible, coinsurance and stoploss provisions, which are exclusive of and shall not be included in the dollar limitation for hospice care benefits as specified in (2) above.

(a) Bereavement support services for the family of the deceased person during the twelve month period following death, and in no event shall this maximum benefit be no less than $1150.

The Company's certificates and policies do not include all the required benefits for Home Health Services and Hospice Care as indicated below.

The Company's Choice COC Amendment, form number CHCAMD.H.01.CO, applicable to policies issued in the 2009 – 2001 Series Group, shown below does not include a list of all of the required Home Health Care benefits.

1. Home Health Care

Services received from a Home Health Agency that are both of the following:

- Ordered by a Physician.
- Provided by or supervised by a registered nurse in your home.

Benefits are available only when the Home Health Agency services are provided on a part-time, intermittent schedule and when skilled care is required.

Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- It is ordered by a Physician.
- It is not delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.
- It is not Custodial Care.

We will decide if skilled care is required by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

| | |
|---|---|
| State Mandate | Must cover at least 60 visits. |
| Group [Para] | Include when group chooses to limit benefit. |
| Group [text] | [1]Insert benefit limit selected by group. Standard is 60 visits. |

**[**Benefits are limited to [[1]60 - 200] visits per calendar year. One visit equals four hours of skilled care services.**]**

The Company's four (4) other in force policy forms:

HMO Basic Mandate Benefit Health Benefit Plan for Colorado – Certificate, form number BscChcCOC.H.07.CO;

HMO Standard Health Benefit Plan for Colorado – Certificate, form number StdChcCOC.H.07.CO;

HMO Basic Limited Mandate Health Benefit Plan for Colorado – Conversion Policy, form number PolicyBasConv6109.H.07.CO; and

HMO Standard Health Benefit Plan for Colorado – Conversion Policy, form number PolicyStdConv6109.H.07.CO,

as shown below, do not include the following requirement:

- List of all the required Home Health Care benefits.

These forms include the following:

[6.] Home Health Care

Services received from a Home Health Agency that are both of the following:

- Ordered by a Physician.
- Provided in your home by a registered nurse, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse.

Benefits are available only when the Home Health Agency services are provided on a part-time, Intermittent Care schedule and when skilled care is required.

Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- It is ordered by a Physician.
- It is not delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.
- It is not Custodial Care.

We will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

**Forms amended effective August 21, 2009.** The Company's amended forms do not include all the required benefits for Home Health Services and Hospice Care as indicated below.

The Company's MCE 2009 Amendment – Choice/Select (HMO) – 2001 Series, form number MCE09AMD.H.01.CO, applicable to policies issued in the 2009 – 2001 Series Group, as shown below, does not include:

- Respiratory and inhalation therapy or Nutrition counseling by a nutritionist or dietician in the list of required Home Health Care benefits.

The Company's four (4) other in force amended policy forms:

MCE 2009 Amendment – Basic HMO SB COC, form number MCE09BSCHMOSB.AMD.07.CO;

MCE 2009 Amendment – Standard HMO SB COC, form number MCE09STDHMOSB.AMD.07.CO;

MCE 2009 Amendment – Basic HMO Conversion Policy, form number MCE09BSCHMOCONV.AMD.H.07.CO; and

MCE 2009 Amendment – Standard HMO Conversion Policy, form number MCE09STDHMOCONV.AMD.H.07.CO,

as shown below, do not include the following requirement:

- List of required Home Health Care benefits does not include Respiratory and inhalation therapy or Nutrition counseling by a nutritionist or dietician.

The forms listed above include the following amendment:

Home Health Care

Home health care services received from a Home Health Agency that are both of the following:

- Ordered by a Physician
- Provided in your home by a registered nurse, certified nurse aid or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse.

Benefits are available only when the Home Health Agency services are provided on a part-time, Intermittent Schedule and when skilled care is required. Home health services are to be covered when services are necessary as alternatives to hospitalization, or in place of hospitalization. Prior hospitalization is not a requirement.

Home health care visits may be included but are not limited to:

- Skilled nursing visits;
- Home Health Aide Services visits that provide supportive care in the home which are reasonable and necessary to the Member's illness or injury.
- Physical, occupational, or speech therapy and audiology services that is provided on a per visit basis;
- Medical supplies, Durable Medical Equipment; and
- Infusion therapy medications and supplies and laboratory services as prescribed by a Provider to the extent such services would be covered by us had the Member remained in the hospital, rehabilitation or Skilled Nursing Facility.
- "Medical social services' are those services provided by an individual who possesses a baccalaureate degree in social work, psychology or counseling or the documented equivalent in a combination of education, training and experience, which services are provided at the recommendation of a physician for the purpose of assisting the insured or the family in dealing with a specific medical condition.

Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- It is ordered by a Physician.
- It is not delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.
- It is not custodial care.

We will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

**Forms**

| | **Form Numbers** |
|---|---|
| Choice COC Amendment | CHCAMD.H.01.CO |
| HMO Basic Mandate Benefit Health Benefit Plan for Colorado – Certificate | BscChcCOC.H.07.CO |
| HMO Standard Health Benefit Plan for Colorado – Certificate | StdChcCOC.H.07.CO |
| HMO Basic Limited Mandate Health Benefit Plan for Colorado – Conversion Policy | PolicyBasConv6109.H.07.CO |
| HMO Standard Health Benefit Plan for Colorado – Conversion Policy | PolicyStdConv6109.H.07.CO |

| **Amended Forms** | **Amended Form Numbers** |
|---|---|
| MCE 2009 Amendment – Choice/Select (HMO) – 2001 Series | MCE09AMD.H.01.CO |
| MCE 2009 Amendment – Basic HMO SB COC | MCE09BSCHMOSB.AMD.07.CO |
| MCE 2009 Amendment – Standard HMO SB COC | MCE09STDHMOSB.AMD.07.CO |
| MCE 2009 Amendment – Basic HMO Conversion Policy | MCE09BSCHMOCONV.AMD.H.07.CO |
| MCE 2009 Amendment – Standard HMO Conversion Policy | MCE09STDHMOCONV.AMD.H.07.CO |

**Recommendation No. 6:**

No later than thirty (30) days from the date this report is adopted, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-2-8. In the event the Company is unable to show such proof, it should provide written evidence to the Division that it has corrected all applicable forms to reflect all required benefits for Home Health Services and Hospice Care, as is mandated by Colorado insurance law.

**Issue E6: Failure to reflect completely the situations in which non-emergency care delivered in an emergency room would be covered.**

Emergency Regulation 08-E-12 (effective 1/1/09), Concerning Small Employer Group Health Benefit Plans and The Basic and Standard Health Benefit Plans, promulgated under the authority of §§ 10-1-109, 10-16-105 (7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states in part:

Section 2 Scope and Purpose

The purpose of this emergency regulation is to comply with the enactment of Senate Bill 08-057, which mandates coverage of hearing aids for children under the age of 18 and House Bill 08-1410, concerning the coverage of colorectal cancer prevention services. This emergency regulation specifies the requirements for the basic and standard health benefit plans as well as other requirements for small employer carriers.

Section 3 Applicability

This regulation shall apply to all small employer carriers as defined in §10-16-102(41), C.R.S., and to all carriers required to provide conversion products pursuant to §10-16-108, C.R.S.

BASIC AND STANDARD HEALTH BENEFIT PLAN POLICY REQUIREMENTS FOR THE STATE OF COLORADO

Colorado Division of Insurance

Effective January 1, 2009

1. The basic health benefit plan as defined by the Commissioner pursuant to § 10-16-105(7.2)(b), C.R.S., for an indemnity, preferred provider organization (PPO), and health maintenance organization (HMO) plan shall include the specific benefits and coverages outlined in one of the attached tables labeled "Basic Limited Mandate Health Benefit Plan", Basic HSA Health Benefit Plan", or "Basic HSA Limited Mandate Health Benefit Plan".

2. The standard health benefit plan for an indemnity, PPO, and HMO plan shall include the specific benefits and coverages outlined in the attached table labeled "Standard Health Benefit Plan".

Benefit Grid

January 1, 2009 COLORADO BASIC LIMITED MANDATE HEALTH BENEFIT PLANS:
INDEMNITY, PPO, AND HMO

PART A: TYPES OF COVERAGE

| |
|---|
| 15. EMERGENCY CARE [12, 13] |

Footnotes: 13 Non-emergency care delivered in an emergency room is covered *only if the covered person receiving such care was referred to the emergency room by his/her carrier or* primary care physician. … [Emphasis added.]

Colorado Insurance Regulation 4-6-5 (effective 2/1/09), Concerning Small Employer Group Health Benefit Plans and The Basic and Standard Health Benefit Plans, promulgated under the authority of §§ 10-1-109, 10-16-105 (7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states in part:

. . .

Section 2 Scope and Purpose

The purpose of this amendment is to comply with the enactment of Senate Bill 08-057, which mandates coverage of hearing aids for children under the age of 18 and House Bill 08-1410, concerning the coverage of colorectal cancer prevention services. *This regulation specifies the requirements for the basic and standard health benefit plans as well as other requirements for small employer carriers*. This regulation replaces Emergency Regulation 08-E-12 in its entirety. [Emphasis added.]

Section 3 Applicability

This regulation shall apply to all small employer carriers as defined in § 10-16-102(41), C.R.S. and to all carriers required to provide conversion products pursuant to § 10-16-108, C.R.S.

BASIC AND STANDARD HEALTH BENEFIT PLAN POLICY REQUIREMENTS FOR THE STATE OF COLORADO

Colorado Division of Insurance

Effective February 1, 2009

3. The basic health benefit plan as defined by the Commissioner pursuant to § 10-16-105(7.2)(b), C.R.S., for an indemnity, preferred provider organization (PPO), and health maintenance organization (HMO) plan shall include the specific benefits and coverages outlined in one of the attached tables labeled “Basic Limited Mandate Health Benefit Plan”, Basic HSA Health Benefit Plan”, or “Basic HSA Limited Mandate Health Benefit Plan”.

4. The standard health benefit plan for an indemnity, PPO, and HMO plan shall include the specific benefits and coverages outlined in the attached table labeled “Standard Health Benefit Plan”.

Benefit Grid

February 1, 2009 COLORADO BASIC LIMITED MANDATE HEALTH BENEFIT PLANS:
INDEMNITY, PPO, AND HMO

PART A: TYPES OF COVERAGE

| 15. |
|---|

| EMERGENCY CARE [12, 13] |
|---|

Footnotes: 13 Non-emergency care delivered in an emergency room is covered *only if the covered person receiving such care was referred to the emergency room by his/her carrier or* primary care physician. … [Emphasis added.]

The Company's certificates and forms listed below do not appear to be complete as required by Colorado insurance law. None of the forms included the provision pertaining to non-emergency care delivered in an emergency room.

The Company's basic and standard policy certificates:

HMO Basic Limited Mandate Health Benefit Plan for Colorado – Certificate, form number BasChcCOC.H.07.CO, and

HMO Standard Health Benefit Plan for Colorado – Certificate, form number StdChcCOC.H.07.CO,

both include the following:

[5.] Emergency Health Services - Outpatient

Services that are required to stabilize or initiate treatment in an Emergency. Emergency Health Services must be received on an outpatient basis at a Hospital or Alternate Facility.

Benefits under this section include the facility charge, supplies and all professional services required to stabilize your condition and/or initiate treatment. This includes placement in an observation bed for the purpose of monitoring your condition (rather than being admitted to a Hospital for an Inpatient Stay).

Health care services provided at a Network facility, including services provided by a Non-Network provider, are to be provided to you at no greater cost than if the services were obtained by a Network provider.

In the case of Emergency, you may call the 911 emergency telephone access number or its local equivalent. We provide Benefits for Eligible Expenses resulting from the use of emergency telephone access numbers in the case of an Emergency.

The Company's basic and standard conversion policy forms:

HMO Basic Limited Mandate Health Benefit Plan for Colorado – Conversion Policy, form number PolicyBasConv6109.H.07.CO, and

HMO Standard Health Benefit Plan for Colorado – Conversion Policy, form number PolicyStdConv6109.H.07.CO,

both include the following:

[5.] Emergency Health Services - Outpatient

Services that are required to stabilize or initiate treatment in an Emergency. Emergency Health Services must be received on an outpatient basis at a Hospital or Alternate Facility.

Benefits under this section include the facility charge, supplies and all professional services required to stabilize your condition and/or initiate treatment. This includes placement in an observation bed for the purpose of monitoring your condition (rather than being admitted to a Hospital for an Inpatient Stay).

Health care services provided at a Network facility, including services provided by a Non-Network provider, are to be provided to you at no greater cost than if the services were obtained by a Network provider.

In the case of Emergency, you may call the 911 emergency telephone access number or its local equivalent. We provide Benefits for Eligible Expenses resulting from the use of emergency telephone access numbers in the case of an Emergency.

| **Forms** | **Form Numbers** |
|---|---|
| HMO Basic Limited Mandate Health Benefit Plan for Colorado – Certificate | BasChcCOC.H.07.CO |
| HMO Standard Health Benefit Plan for Colorado – Certificate | StdChcCOC.H.07.CO |
| HMO Basic Limited Mandate Health Benefit Plan for Colorado – Conversion Policy | PolicyBasConv6109.H.07.CO |
| HMO Standard Health Benefit Plan for Colorado – Conversion Policy | PolicyStdConv6109.H.07.CO |

**Recommendation No. 7:**

No later than thirty (30) days from the date this report is adopted, the Company should provide documentation demonstrating why it should not be considered in violation of Emergency Regulation 08-E-12 and Amended Colorado Insurance Regulation 4-6-5. In the event the Company is unable to show such proof, it should provide written evidence to the Division that it has revised the language regarding coverage for non-emergency care delivered in an emergency room to comply with Colorado insurance law. The Division's records indicate that the Respondent has revised the language in the cited forms which, if fully implemented appears to comply with the corrective actions ordered concerning this violation. The statement is only applicable to the situations in which non-emergency care delivered in an emergency room would be covered, and nothing in this paragraph should be construed as approval of the language in the health benefit plans as a whole.

**Issue E7: Failure to reflect the mandated minimum hours of hospital stay to be provided for normal and cesarean section deliveries.**

Section 10-16-104, C.R.S., Mandatory coverage provisions – definitions, states in part:

(1) Newborn Children

(b)(I) Coverage for a hospital stay for a newborn following a normal vaginal delivery shall not be limited to less than forty-eight hours. *If forty-eight hours following delivery falls after 8 p.m., coverage shall continue until 8 a.m. the following morning.*

(II) Coverage for a hospital stay for a newborn following a cesarean section shall not be limited to less than ninety-six hours. *If ninety-six hours following the cesarean section falls after 8:00 p.m., coverage shall continue until 8 a.m. the following morning*.

. . .

(3) Maternity coverage

(a)(II) Coverage for a hospital stay following a normal vaginal delivery shall not be limited to less than forty-eight hours. *If forty-eight hours following delivery falls after 8 p.m., coverage shall continue until 8 a.m. the following morning*.

(III) Coverage for a hospital stay following a cesarean section shall not be limited to less than ninety-six hours. *If ninety-six hours following the cesarean section falls after 8 p.m., coverage shall continue until 8 a.m. the following morning. [Emphases added.]*

The Company's certificates and forms listed below do not appear to be complete as required by Colorado insurance law. None of the forms include the provision that if the ninety-six hours following either the normal vaginal delivery or delivery by cesarean section falls after 8 p.m., coverage shall continue until 8 a.m. the following morning.

The Company's 2004 Choice Certificate of Coverage, form number CHOICECO.01 (12-2003), states in part:

14. Maternity Services

Benefits for Pregnancy will be paid at the same level as Benefits for any other condition, Sickness or Injury. This includes all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications.

We also have special prenatal programs to help during Pregnancy. They are completely voluntary and there is no extra cost for participating in the program. To sign up, you should notify us during the first trimester, but no later than one month prior to the anticipated childbirth.

We will pay Benefits for an Inpatient Stay of at least:

- 48 hours for the mother and newborn child following a normal vaginal delivery.

- 96 hours for the mother and newborn child following a cesarean section delivery.

If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames.

The Company's basic and standard policy certificates:

HMO Basic Limited Mandate Health Benefit Plan for Colorado – Certificate, form number BasChcCOC.H.07.CO, and

HMO Standard Health Benefit Plan for Colorado – Certificate, form number StdChcCOC.H.07.CO,

both include the following:

[13.] Pregnancy - Maternity Services

Benefits for Pregnancy include all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications.

Both before and during a Pregnancy, Benefits include the services of a genetic counselor when provided or referred by a Physician. Benefits include genetic counseling and testing when there is a reasonable probability that, because of family history, parental age, or exposure to an agent which might cause birth defects or cancer in the fetus, the results will affect medical decisions involving the existing Pregnancy.

These Benefits are available to all Covered Persons in the immediate family. Covered Health Services include related tests and treatment. We also have special prenatal programs to help during Pregnancy. They are completely voluntary and there is no extra cost for participating in the program. To sign up, you should notify us during the first trimester, but no later than one month prior to the anticipated childbirth. It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs designed to achieve the best outcomes for you and your baby.

We will pay Benefits for an Inpatient Stay of at least:

- 48 hours for the mother and newborn child following a normal vaginal delivery.
- 96 hours for the mother and newborn child following a cesarean section delivery.

If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames.

The Company's basic and standard conversion policy forms:

HMO Basic Limited Mandate Health Benefit Plan for Colorado – Conversion Policy, form number PolicyBasConv6109.H.07.CO, and

HMO Standard Health Benefit Plan for Colorado – Conversion Policy, form number PolicyStdConv6109.H.07.CO,

both include the following:

[14.] Pregnancy - Maternity Services

Benefits for Pregnancy include all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications.

Both before and during a Pregnancy, Benefits include the services of a genetic counselor when provided or referred by a Physician. Benefits include genetic counseling and testing when there is a reasonable probability that, because of family history, parental age, or exposure to an agent which might cause birth defects or cancer in the fetus, the results will affect medical decisions involving the existing Pregnancy. These Benefits are available to all Covered Persons in the immediate family. Covered Health Services include related tests and treatment.

We also have special prenatal programs to help during Pregnancy. They are completely voluntary and there is no extra cost for participating in the program. To sign up, you should notify us during the first trimester, but no later than one month prior to the anticipated childbirth. It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs designed to achieve the best outcomes for you and your baby.

We will pay Benefits for an Inpatient Stay of at least:

- 48 hours for the mother and newborn child following a normal vaginal delivery.
- 96 hours for the mother and newborn child following a cesarean section delivery.

If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames.

| **Forms** | **Form Numbers** |
|---|---|
| 2004 Choice Certificate of Coverage | CHOICECO.01 (12-2003) |
| HMO Basic Limited Mandate Health Benefit Plan for Colorado – Certificate | BasChcCOC.H.07.CO |
| HMO Standard Health Benefit Plan for Colorado – Certificate | StdChcCOC.H.07.CO, |
| HMO Basic Limited Mandate Health Benefit Plan for Colorado – Conversion Policy | PolicyBasConv6109.H.07.CO |
| HMO Standard Health Benefit Plan for Colorado – Conversion Policy | PolicyStdConv6109.H.07.CO |

**Recommendation No. 8:**

No later than thirty (30) days from the date this report is adopted, the Company should provide documentation demonstrating why it should not be considered in violation of §10-16-104, C.R.S. In the event the Company is unable to show such proof, it should provide written evidence to the Division that it has revised all applicable forms to correctly reflect the mandated minimum hours of hospital stay to be provided for normal and cesarean section deliveries. The Division's records indicate that the Respondent has revised the language in the cited forms which, if fully implemented appears to comply with the corrective actions ordered concerning this violation. The statement is only applicable to the benefit descriptions for the mandated minimum hours of hospital stay to be provided for normal and cesarean section deliveries, and nothing in this paragraph should be construed as approval of the language in the health benefit plans as a whole.

**Issue E8: Failure to reflect accurate requirements to qualify as dependent.**

Section 10-16-102, C.R.S., Definitions, states in part:

> . . .
>
> (14) "Dependent" means a spouse, an unmarried child under nineteen years of age, an unmarried child who is a full-time student under twenty-four years of age and who is financially dependent upon the parent, and an unmarried child of any age who is medically certified as disabled and dependent upon the parent.

Section 10-16-104, C.R.S., Mandatory coverage provisions – definitions, states in part:

> . . .
>
> (6) Dependent children.
>
> . . .
>
> (b) No entity described in paragraph (a) of this subsection (6) *shall refuse to provide coverage for a dependent child* under the health plan of the child's parent for the sole reason that the child:
>
> (I) *Does not live in the home* of the parent applying for this policy; or
>
> (II) *Does not live in the insurer's service area*, notwithstanding any other provision of law restricting enrollment to persons who reside in an insurer's service area; [Emphases added.]

The Company's certificates and forms listed below do not appear to be complete as required by Colorado insurance law as they do not appear to reflect accurate requirements for qualifying as a dependent. Colorado insurance law does not include the requirements that a child must reside within the Service Area or reside with the Subscriber who works within the Service Area.

The Company's HMO Small Group/Key Accounts Schedule of Benefits Amendments, form number MandatedBenefits.H.01.CO, applicable to policies issued in the 2009 – 2001 Series Groups, states in part:

> Section 10: Glossary of Defined Terms:
>
> *Dependent* - To be eligible for coverage under the Policy, a Dependent (other than an unmarried dependent child) must reside within the Service Area or reside with the Subscriber who works within the Service Area.

The Company's basic and standard policy certificates:

> HMO Basic Limited Mandate Health Benefit Plan for Colorado – Certificate, form number BasChcCOC.H.07.CO, and
>
> HMO Standard Health Benefit Plan for Colorado – Certificate, form number StdChcCOC.H.07.CO,

both include the following:

Section 9: Defined Terms

Dependent –

To be eligible for coverage under the Policy, a Dependent (other than an unmarried dependent child) must reside within the Service Area or reside with the Subscriber who works within the Service Area.

- Dependent includes any unmarried dependent child under [25-30] years of age only if you furnish evidence upon our request, satisfactory to us, that:
  - The child is financially dependent upon the Subscriber or the Subscriber's spouse for support and maintenance; or
  - The child has the same legal residence as the Subscriber.

The Company's basic and standard conversion policy forms:

HMO Basic Limited Mandate Health Benefit Plan for Colorado – Conversion Policy, form number PolicyBasConv6109.H.07.CO, and

HMO Standard Health Benefit Plan for Colorado – Conversion Policy, form number PolicyStdConv6109.H.07.CO,

both include the following:

Section 8: Defined Terms

- A Dependent includes any unmarried dependent child under 25 years of age only if you furnish evidence upon our request, satisfactory to us, that:
  - The child is financially dependent upon the Subscriber or the Subscriber's spouse for support and maintenance; or
  - The child has the same legal residence as the Subscriber.

| **Forms** | **Form Numbers** |
|---|---|
| HMO Small Group/Key Accounts Schedule of Benefits Amendments | MandatedBenefits.H.01.CO |
| HMO Basic Limited Mandate Health Benefit Plan for Colorado – Certificate | BasChcCOC.H.07.CO |
| HMO Standard Health Benefit Plan for Colorado – Certificate | StdChcCOC.H.07.CO |
| HMO Basic Limited Mandate Health Benefit Plan for Colorado – Conversion Policy | PolicyBasConv6109.H.07.CO |
| HMO Standard Health Benefit Plan for Colorado – Conversion Policy | PolicyStdConv6109.H.07.CO |

**Recommendation No. 9:**

No later than thirty (30) days from the date this report is adopted, the Company should provide documentation demonstrating why it should not be considered in violation of §§ 10-16-102 and 10-16-104, C.R.S. In the event the Company is unable to show such proof, it should provide written evidence to the Division that it has corrected all applicable forms to reflect accurate requirements to qualify as a dependent as is required by Colorado insurance law. The Division's records indicate that the Respondent has revised the language in the cited forms which, if fully implemented appears to comply with the corrective actions ordered concerning this violation. The statement is only applicable to the requirements to qualify as dependent, and nothing in this paragraph should be construed as approval of the language in the health benefit plans as a whole.

**Issue E9: Failure to reflect a complete description of mandatory coverage for child health supervision services.**

Section 10-16-104., C.R.S., Mandatory coverage provisions - definitions states in part:

(11) Child health supervision services

(a) For purposes of this subsection (11), unless the context otherwise requires, "*child health supervision services" means those preventive services and immunizations required to be provided in basic and standard health benefit plans pursuant to section 10-16-105 (7.2),* to dependent children up to age thirteen. Such services shall be provided by a physician or pursuant to a physician's supervision or by a primary health care provider who is a physician's assistant or registered nurse who has additional training in child health assessment and who is working in collaboration with a physician.

Emergency Regulation 08-E-12 (effective 1/1/09), Concerning Small Employer Group Health Benefit Plans and The Basic and Standard Health Benefit Plans, promulgated pursuant to §§ 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states in part:

Attachment 1

| Covered Preventive Services [1] | |
|---|---|
| All children | Immunizations.<br>*Immunization deficient children are not bound by "recommended ages*".<br>[Emphasis added.] |

Colorado Insurance Regulation 4-6-5, (effective 2/1/09), Concerning Small Employer Group Health Benefit Plans and The Basic and Standard Health Benefit Plans, promulgated pursuant to §§ 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states in part:

Attachment 1

| Covered Preventive Services [1] | |
|---|---|
| All children | Immunizations.<br>*Immunization deficient children are not bound by "recommended ages*".<br>[Emphasis added.] |

The Company's certificates and forms listed below do not appear to be complete as required by Colorado insurance law as they do not appear to reflect the required language that immunizations for deficient children are not bound by 'recommended ages.'

The Company's HMO Small Group/Key Accounts Schedule of Benefits Amendment, form number MandatedBenefits.H.01.CO, applicable to policies issued in the 2009 – 2001 Series Groups, states in part:

*Child Health Supervision Services -* those preventive services and immunizations required to be provided to dependent children up to age 13 as follows:

- Age 0 – 12 months: One newborn home visit during the first week of life if the newborn is released from the Hospital less than 48 hours after delivery. Five well-child visits. One PKU.

- Age 13 – 35 months: Two well child visits.
- Age 3 – 6: Three well child visits.
- Age 7 – 12: Three well child visits.
- All children: Immunizations.

The Company's basic and standard policy certificates:

HMO Basic Limited Mandate Health Benefit Plan for Colorado – Certificate, form number BasChcCOC.H.07.CO, and

HMO Standard Health Benefit Plan for Colorado – Certificate, form number StdChcCOC.H.07.CO,

both include the following:

Child Health Supervision Services - those preventive services and immunizations required to be provided to dependent children up to age 13 as follows:

- 0-12 months: One newborn home visit during the first week of life if the newborn is released from the Hospital less than 48 hours following delivery; six well-child visits; one PKU.
- 13-35 months: Three well-child visits.
- 3-6 years: Four well-child visits.
- 7-12 years: 4 well-child visits
- 0-12 years: Immunizations.

The Company's basic and standard conversion policy forms:

HMO Basic Limited Mandate Health Benefit Plan for Colorado – Conversion Policy, form number PolicyBasConv6109.H.07.CO, and

HMO Standard Health Benefit Plan for Colorado – Conversion Policy, form number PolicyStdConv6109.H.07.CO,

both include the following:

Child Health Supervision Services - those preventive services and immunizations required to be provided to dependent children up to age 13 as follows:

- 0-12 months: One newborn home visit during the first week of life if the newborn is released from the Hospital less than 48 hours following delivery; six well-child visits; one PKU.
- 13-35 months: Three well-child visits.
- 3-6 years: Four well-child visits.
- 7-12 years: 4 well-child visits
- 0-12 years: Immunizations.

| **Forms** | **Form Numbers** |
|---|---|
| HMO Small Group/Key Accounts Schedule of Benefits Amendment | MandatedBenefits.H.01.CO |
| HMO Basic Limited Mandate Health Benefit Plan for Colorado – Certificate | BasChcCOC.H.07.CO |
| HMO Standard Health Benefit Plan for Colorado – Certificate | StdChcCOC.H.07.CO |
| HMO Basic Limited Mandate Health Benefit Plan for Colorado – Conversion Policy | PolicyBasConv6109.H.07.CO |
| HMO Standard Health Benefit Plan for Colorado – Conversion Policy | PolicyStdConv6109.H.07.CO |

**Recommendation No. 10:**

No later than thirty (30) days from the date this report is adopted, the Company should provide documentation demonstrating why it should not be considered in violation of §10-16-104, C.R.S., and Colorado Emergency Regulation 08-E-12 and Amended Insurance Regulation 4-6-5. In the event the Company is unable to show such proof, it should provide written evidence to the Division that it has revised all applicable forms to reflect complete descriptions of the mandated child health supervision services as is required by Colorado insurance law. The Division's records indicate that the Respondent has revised the language in the cited forms which, if fully implemented appears to comply with the corrective actions ordered concerning this violation. The statement is only applicable to the description of mandatory coverage for child health supervision services, and nothing in this paragraph should be construed as approval of the language in the health benefit plans as a whole.

**Issue E10: Failure to reflect correct procedures for adding benefits, making changes, modifications or withdrawals with amendments to the Basic and Standard Health Benefit plans.**

Emergency Regulation 08-E-12 (effective 1/1/09), Concerning Small Employer Group Health Benefit Plans and The Basic and Standard Health Benefit Plans, promulgated under the authority of §§ 10-1-109, 10-16-105 (7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states in part:

> Section 2 Scope and Purpose
>
> The purpose of this emergency regulation is to comply with the enactment of Senate Bill 08-057, which mandates coverage of hearing aids for children under the age of 18 and House Bill 08-1410, concerning the coverage of colorectal cancer prevention services. This emergency regulation specifies the requirements for the basic and standard health benefit plans as well as other requirements for small employer carriers.
>
> Section 3 Applicability
>
> This regulation shall apply to all small employer carriers as defined in § 10-16-102(41), C.R.S. and to all carriers required to provide conversion products pursuant to § 10-16-108, C.R.S.
>
> BASIC AND STANDARD HEALTH BENEFIT PLAN POLICY REQUIREMENTS FOR THE STATE OF COLORADO
>
> Colorado Division of Insurance
>
> January 1, 2009
>
> . . .
>
> 1. The basic health benefit plan as defined by the Commissioner pursuant to § 10-16-105(7.2)(b), C.R.S., for an indemnity, preferred provider organization (PPO), and health maintenance organization (HMO) plan shall include the specific benefits and coverages outlined in one of the attached tables labeled "Basic Limited Mandate Health Benefit Plan", Basic HSA Health Benefit Plan", or "Basic HSA Limited Mandate Health Benefit Plan".
>
> 2. The standard health benefit plan for an indemnity, PPO, and HMO plan shall include the specific benefits and coverages outlined in the attached table labeled "Standard Health Benefit Plan".
>
> . . .
>
> 5. All basic and standard health benefit plans shall also comply with the following requirements:
>
> . . .
>
> B. Benefit Modifications: The form and level of coverages specified in the tables labeled "Basic Limited Mandate Health Benefit Plan", Basic HSA Health Benefit Plan", "Basic HSA Limited Mandate Health Benefit Plan"

and "Standard Health Benefit Plan" *may be expanded to add additional coverage through a rider or endorsement at the option of the policyholder only*. [Emphasis added.]

Colorado Insurance Regulation 4-6-5, (effective 2/1/09), Concerning Small Employer Group Health Benefit Plans and The Basic and Standard Health Benefit Plans, promulgated under the authority of §§ 10-1-109, 10-16-105 (7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states in part:

Section 2 Scope and Purpose

The purpose of the amendment to this regulation is to comply with the enactment of Senate Bill 08-057, which mandates coverage of hearing aids for children under the age of 18 and House Bill 08-1410, concerning the coverage of colorectal cancer prevention services. *This regulation specifies the requirements for the basic and standard health benefit plans as well as other requirements for small employer carriers*. This regulation replaces Emergency Regulation 08-E-12 in its entirety. [Emphasis added.]

Section 3 Applicability

This regulation shall apply to all small employer carriers as defined in § 10-16-102(41), C.R.S. and to all carriers required to provide conversion products pursuant to § 10-16-108, C.R.S.

BASIC AND STANDARD HEALTH BENEFIT PLAN POLICY REQUIREMENTS FOR THE STATE OF COLORADO

Colorado Division of Insurance

February 1, 2009

. . .

1. The basic health benefit plan as defined by the Commissioner pursuant to § 10-16-105(7.2)(b), C.R.S., for an indemnity, preferred provider organization (PPO), and health maintenance organization (HMO) plan shall include the specific benefits and coverages outlined in one of the attached tables labeled "Basic Limited Mandate Health Benefit Plan", Basic HSA Health Benefit Plan", or "Basic HSA Limited Mandate Health Benefit Plan".

2. The standard health benefit plan for an indemnity, PPO, and HMO plan shall include the specific benefits and coverages outlined in the attached table labeled "Standard Health Benefit Plan".

. . .

5. All basic and standard health benefit plans shall also comply with the following requirements:

. . .

B. Benefit Modifications: The form and level of coverages specified in the

> tables labeled "Basic Limited Mandate Health Benefit Plan", Basic HSA Health Benefit Plan", "Basic HSA Limited Mandate Health Benefit Plan" and "Standard Health Benefit Plan" *may be expanded to add additional coverage through a rider or endorsement at the option of the policyholder only*. [Emphasis added.]

The Company's certificates and forms listed below reflect that the Company may add benefits via an amendment to the policy at its sole discretion. This appears to be incorrect as Colorado Insurance Regulation 4-6-5 specifically indicates that these plans may add additional coverage through a rider or endorsement only at the option of the policyholder. Additionally, the requirements of the benefits to be provided by these plans are determined by the Regulation and do not allow changes, modifications or withdrawals at the Company's discretion.

The Company's basic and standard policy certificates listed below both include the following:

> HMO Basic Limited Mandate Health Benefit Plan for Colorado – Certificate, form number BasChcCOC.H.07.CO, and
>
> HMO Standard Health Benefit Plan for Colorado – Certificate, form number StdChcCOC.H.07.CO,
>
> Section 8: General Legal Provisions
>
> Amendments to the Policy
>
> > To the extent permitted by law we reserve the right, in our sole discretion and without your approval, to change, interpret, modify, or add Benefits or terminate the Policy.

The Company's basic and standard conversion policy forms:

> HMO Basic Limited Mandate Health Benefit Plan for Colorado – Conversion Policy, form number PolicyBasConv6109.H.07.CO, and
>
> HMO Standard Health Benefit Plan for Colorado – Conversion Policy, form number PolicyStdConv6109.H.07.CO,

both include the following:

> Section 7: General Legal Provisions
>
> Amendments to the Policy
>
> > To the extent permitted by law we reserve the right, in our sole discretion and without your approval, to change, interpret, modify, or add Benefits or terminate the Policy.

| **Forms** | **Form Numbers** |
|---|---|
| HMO Basic Limited Mandate Health Benefit Plan for Colorado – Certificate | BasChcCOC.H.07.CO |
| HMO Standard Health Benefit Plan for Colorado – Certificate | StdChcCOC.H.07.CO |

| | |
|---|---|
| HMO Basic Limited Mandate Health Benefit Plan for Colorado – Conversion Policy | PolicyBasConv6109.H.07.CO |
| HMO Standard Health Benefit Plan for Colorado – Conversion Policy | PolicyStdConv6109.H.07.CO |

**Recommendation No. 11:**

No later than thirty (30) days from the date this report is adopted, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Emergency Regulation 08-E-12 and Amended Insurance Regulation 4-6-5. In the event the Company is unable to show such proof, it should provide written evidence to the Division that it has revised its language concerning amendments to the Basic and Standard Health Benefit Plans which complies with Colorado insurance law. The Division's records indicate that the Respondent has revised the language in the cited forms which, if fully implemented appears to comply with the corrective actions ordered concerning this violation. The statement is only applicable to the procedures for adding benefits, and nothing in this paragraph should be construed as approval of the language in the health benefit plans as a whole.

**Issue E11: Failure to include a disclosure regarding the mechanisms to obtain the carrier's reimbursement rates to nonparticipating providers.**

Section 10-3-1104, C.R.S., Unfair method of competition and unfair or deceptive acts or practices, states in part:

> (1) The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:
>
> . . .
>
> (b) False information and advertising generally: Making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio or television station, or in any other way, an advertisement, announcement, or statement containing any assertion, representation, or statement with respect to the business of insurance, or with respect to any person in the conduct of his insurance business, which is untrue, deceptive, or misleading;

Section 10-16-704, C.R.S., Network adequacy – rules – legislative declaration – repeal, states in part:

> . . .
>
> (2)(d) *The carrier shall provide, in conspicuous, bold-faced type, an understandable disclosure in policy contract materials, certificates of coverage for a policyholder, and marketing materials about the following:*
>
> . . .
>
> (III) *The mechanisms to obtain the carrier's reimbursement rates to nonparticipating providers for specific covered health care services.* [Emphases added.]

The Company's definition of eligible expenses as set forth in each of the reviewed policy forms does not provide sufficient information for the member to determine potential liability for non-network claims nor does it provide sufficient information for the member to determine if the non-network claim was correctly processed. In addition, the cited definitions in the basic and standard certificates and in the basic and standard conversion forms set forth four or more criteria under which the Company, *at its discretion,* will determine the amount payable for non-network claims and does not state with specificity the mechanisms to obtain the carrier's reimbursement rates as required.

The Company's basic and standard policy certificates:

> HMO Basic Limited Mandate Health Benefit Plan for Colorado – Certificate, form number BasChcCOC.H.07.CO, and
>
> HMO Standard Health Benefit Plan for Colorado – Certificate, form number StdChcCOC.H.07.CO,

both include the following:

Section 9: Defined Terms

Eligible Expenses - for Covered Health Services, incurred while the Policy is in effect, Eligible Expenses are determined by us as stated below and as detailed in the *Schedule of Benefits*.

Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines. We develop our reimbursement policy guidelines, in our discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services(CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that we accept.

The Company's basic and standard conversion policy forms:

HMO Basic Limited Mandate Health Benefit Plan for Colorado – Conversion Policy, form number PolicyBasConv6109.H.07.CO, and

HMO Standard Health Benefit Plan for Colorado – Conversion Policy, form number PolicyStdConv6109.H.07.CO,

both include the following:

Section 8: Defined Terms

Eligible Expenses - for Covered Health Services, incurred while the Policy is in effect, Eligible Expenses are determined by us as stated below and as detailed in the *Schedule of Benefits*.

Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines. We develop our reimbursement policy guidelines, in our discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services(CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that we accept.

| **Forms** | **Form Numbers** |
|---|---|
| HMO Basic Limited Mandate Health Benefit Plan for Colorado – Certificate | BasChcCOC.H.07.CO |

| | |
|---|---|
| HMO Standard Health Benefit Plan for Colorado – Certificate | StdChcCOC.H.07.CO |
| HMO Basic Limited Mandate Health Benefit Plan for Colorado – Conversion Policy | PolicyBasConv6109.H.07.CO |
| HMO Standard Health Benefit Plan for Colorado – Conversion Policy | PolicyStdConv6109.H.07.CO |

**Recommendation No. 12 :**

No later than thirty (30) days from the date this report is adopted, the Company should provide documentation demonstrating why it should not be considered in violation of §§10-3-1104 and 10-16-704, C.R.S. In the event the Company is unable to show such proof, it should provide written evidence to the Division that it has revised all applicable forms to include in conspicuous, boldfaced type, an understandable disclosure regarding the mechanisms to obtain the carrier's reimbursement rates to nonparticipating providers, as is required by Colorado insurance law. The Division's records indicate that the Respondent has revised the language in the cited forms which, if fully implemented appears to comply with the corrective actions ordered concerning this violation. The statement is only applicable to a disclosure regarding the mechanisms to obtain the carrier's reimbursement rates to nonparticipating providers, and nothing in this paragraph should be construed as approval of the language in the health benefit plans as a whole.

**Issue E12: Failure to reflect the correct format and/or benefits in the Basic and Standard Health Benefit Plan Description Forms.**

Colorado Insurance Regulation 4-2-20, Concerning the Colorado Health Benefit Plan Description Form, promulgated pursuant to Sections 10-1-109, 10-3-1110(1), 10-16-108.5(11)(b), and 10-16-109, C.R.S., states in part:

> Section 3. Applicability
>
> This amended regulation shall apply to all carriers offering or providing health benefit plan coverage or Medicare supplemental coverage on or after July 1, 2007.
>
> Section 4. Rules
>
> . . .
>
> C. *Carriers shall use the exact format found in Appendix A for the Colorado Health Benefit Plan Description Form, including all headings, notes, row numbers, and footnotes*. . . . [Emphasis added.]
>
> . . .
>
> Section 7. Effective Date
>
> This amended regulation is effective on July 1, 2007.

Emergency Regulation 08-E-12 (effective 1/1/09), Concerning Small Employer Group Health Benefit Plans and The Basic and Standard Health Benefit Plans, promulgated under the authority of §§ 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states in part:

> Section 2 Scope and Purpose
>
> The purpose of this emergency regulation is to comply with the enactment of Senate Bill 08-057, which mandates coverage of hearing aids for children under the age of 18 and House Bill 08-1410, concerning the coverage of colorectal cancer prevention services. This emergency regulation specifies the requirements for the basic and standard health benefit plans as well as other requirements for small employer carriers.
>
> BASIC AND STANDARD HEALTH BENEFIT PLAN POLICY REQUIREMENTS FOR THE STATE OF COLORADO
>
> Colorado Division of Insurance
>
> January 1, 2009
>
> 1. The basic health benefit plan as defined by the Commissioner pursuant to §10-16-105(7.2)(b), C.R.S., for an indemnity, preferred provider plan (PPO), and health maintenance organization (HMO) plan shall include the specific benefits and coverages outlined in one of the attached tables labeled “Basic Limited Mandate Health Benefit Plan”, “Basic HSA Health Benefit Plan”, or “Basic HSA Limited Mandate Health Benefit Plan”.

2. The standard health benefit plan for an indemnity, PPO, and HMO plan *shall include the specific benefits and coverages outlined in the attached table labeled* "Standard Health Benefit Plan". [Emphasis added.]

3. All provisions of Title 10, Article 16 of the Colorado Revised Statutes that apply to small employer group plans shall apply to the basic and standard health benefit plans.

Colorado Insurance Regulation 4-6-5 (effective 2/1/09), Concerning Small Employer Group Health Benefit Plans and The Basic and Standard Health Benefit Plans, promulgated under the authority of §§ 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states in part:

Section 2 Scope and Purpose

The purpose of the amendment to this regulation is to comply with the enactment of Senate Bill 08-057, which mandates coverage of hearing aids for children under the age of 18 and House Bill 08-1410, concerning the coverage of colorectal prevention services. *This regulation specifies the requirements for the basic and standard health benefit plan as well as other requirements for small employer carriers*. This regulation replaces Emergency Regulation 08-E-12 in its entirety. [Emphasis added.]

BASIC AND STANDARD HEALTH BENEFIT PLAN POLICY REQUIREMENTS FOR THE STATE OF COLORADO

Colorado Division of Insurance

February 1, 2009

1. The basic health benefit plan as defined by the Commissioner pursuant to §10-16-105(7.2)(b), C.R.S., for an indemnity, preferred provider plan (PPO), and health maintenance organization (HMO) plan shall include the specific benefits and coverages outlined in one of the attached tables labeled "Basic Limited Mandate Health Benefit Plan", "Basic HSA Health Benefit Plan", or "Basic HSA Limited Mandate Health Benefit Plan".

2. The standard health benefit plan for an indemnity, PPO, and HMO plan *shall include the specific benefits and coverages outlined in the attached table labeled* "Standard Health Benefit Plan". [Emphasis added.]

3. All provisions of Title 10, Article 16 of the Colorado Revised Statutes that apply to small employer group plans shall apply to the basic and standard health benefit plans.

The following eight (8) Health Benefit Plan Description Forms, as provided by the Company, do not appear to be in the correct format as required by Colorado insurance law as indicated below in the column labeled "Company Used."

**Description Form Name: United Healthcare Choice Plan LOC**

| | **Required Information/Format:** | **Company Used:** |
|---|---|---|
| **Part A: Type of Coverage** | | |
| 1. Type of Plan | Health Maintenance Organization **(HMO)** | Health Maintenance Organization *[Company did not include* |

| | | |
|---|---|---|
| | | *"HMO"]* |
| 3. Areas of CO | Plan is available in the following **areas**: | Plan is available in the following counties: *[Company specifies "counties" instead of areas.]* |

**Part B: Summary of Benefits**

| | | |
|---|---|---|
| Column Headers | In-Network Only (out-of-network care is not covered except as noted) | IN NETWORK<br>*[Company did not use correct header.]* |
| Item 4. | 4. Deductible Type[2] | *[Company did not include Item 4. Deductible Type with superscript 2.]* |
| Item 4a. | 4a. ANNUAL DEDUCTIBLE[2a]<br>a) [Individual][Single][2b]<br>b) [Family] [Non-single][2c] | 4a. ANNUAL DEDUCTIBLE<br>a) Individual<br>b) Family<br>*[Company does not include superscripts 2a, 2b, or 2c.]* |
| Item 8. | 8. MEDICAL OFFICE VISITS[4] | 8. ROUTINE MEDICAL OFFICE VISITS[4]<br>*[Name of item is incorrect]* |
| **Endnotes** | | |
| Endnote 1 | "Network" refers to . . . | "Network" refers to . . . |
| Endnote 2 | "Deductible Type" indicates whether the deductible period is "Calendar Year" (January 1 through December 31) or "Benefit Year" (i.e. based on a benefit year beginning on the policy's anniversary date) or if the deductible is based on other requirements such as a "Per Accident or Injury" or "Per Confinement". | *[No Item 2]* |
| Endnote 2b | "individual" means the deductible amount you and each individual covered by a non-HSA qualified policy will have to pay for allowable covered expenses before the carrier will cover those expenses.<br>"Single" means the deductible amount you will have to pay for allowable covered expenses under an HSA-qualified health plan when you are the only individual covered by the plan. | *[No Item 2b]* |

| | | |
|---|---|---|
| Endnote 2c | "Family" is the maximum deductible amount that is required to be met for all family members covered by a non-HAS qualified policy and it may be an aggregated amount (e.g., "$3,000 per family") or specified as the number of individual deductibles that must be met (e.g., "3 deductibles per family"). "Non-single" is the deductible amount that must be met by one or more family members covered by an HSA-qualified plan before any covered expenses will be paid. | *[No Item 2c]* |
| Endnote 3 | "Out-of-pocket maximum" means . . . | "Out-of-pocket maximum" means . . . |
| Endnote 4 | Medical office visits include . . . | Routine medical office visits include . . . |
| Endnote 7 | "Emergency care" means . . . | "Emergency care" means . . . |
| Endnote 9 | "Biologically based mental illnesses" | "Biologically based mental illnesses" |
| Endnote 10 | Waiver of pre-existing condition exclusions. | Waiver of pre-existing condition exclusions. |
| Endnote 11 | Grievances. | Grievances. |

[Note: Prescribed formatting for endnotes does not include an underline of the word or term being defined.]

**Description Form Name: Basic HMO Choice Plan JDJ**

| | **Required Information/Format:** | **Company Used:** |
|---|---|---|
| **Part A: Type of Coverage** | | |
| 1. Type of Plan | Health Maintenance Organization **(HMO)** | Health Maintenance Organization *[Company did not include "HMO"]* |
| 3. Areas of CO | Plan is available in the following **areas**: | Plan is available in the following counties: *[Company specifies "counties" instead of areas.]* |
| **Part B: Summary of Benefits** | | |
| Column Headers | In-Network Only (out-of-network care is not covered except as noted) | IN-NETWORK *[Company did not use correct header.]* |
| **Part C: Limitations and Exclusions** | | |
| Item 35. | Exclusions vary by policy. A list of exclusions is available immediately upon request from your carrier, agent, or plan sponsor. Review the list to see if a service or treatment you may need is excluded from the policy. | Exclusions vary by policy. A list of exclusions is available immediately upon request from your carrier, agent, or plan sponsor. Review **them** to see if a service or treatment you may need is excluded from the policy. *[Company used "them" instead of "the list."] [Emphasis added.]* |

**Part D: Using the Plan**

| | | |
|---|---|---|
| Item 37. | (1) "Yes" or (2) "No". If the answer is "Yes", a carrier may expand on the answer to note exceptions to this requirement (e.g., 'Yes, except for obstetrical or gynecological care.") | Prior notification is required for selected procedures. *[Company did not indicate "yes" or "no".]* |
| Item 39. | Enter your main customer service number for members/insureds. | Prior to receiving ID card, contact your Employer Benefits Administrator.<br>After receiving ID card, contact the Customer Service Department at the toll free number listed on your ID card<br>Sales and Marketing office – 800-516-3344 *[Company did not list customer service number.]* |
| Item 40. | Enter name, address and phone number for complaints and grievances. | Contact the Customer Service Department at toll free number listed on your ID card<br>UnitedHealthcare National Appeals Service Center P O Box 659773<br>San Antonio, TX 78265-9773<br>*[Company did not list phone number for complaints.]* |
| Endnote 1 | "Network" refers to . . . | "Network" refers to . . . |
| Endnote 3 | "Out-of-pocket maximum" means . . . | "Out-of-pocket maximum" means . . . |
| Endnote 7 | "Emergency care" means . . . | "Emergency care" means . . . |
| Endnote 9 | "Biologically based mental illnesses" | "Biologically based mental illnesses" |
| Endnote 10 | Waiver of pre-existing condition exclusions. | Waiver of pre-existing condition exclusions. |
| Endnote 11 | Grievances. | Grievances. |

[Note: Prescribed formatting for endnotes does not include an underline of the word or term being defined.]

**Description Form Name: Standard HMO Choice Plan JDJ**

| | **Required Information/Format:** | **Company Used:** |
|---|---|---|
| **Part A: Type of Coverage** | | |
| 1. Type of Plan | Health Maintenance Organization **(HMO)** | Health Maintenance Organization *[Company did not include "HMO"]* |
| 3. Areas of CO | Plan is available in the following **areas**: | Plan is available in the following counties: *[Company used "counties" instead of "areas."]* |
| **Part B: Summary of Benefits** | | |

| | | |
|---|---|---|
| Column Headers | In-Network Only (out-of-network care is not covered except as noted) | IN-NETWORK *[Company did not use correct header.]* |
| **Part C: Limitations and Exclusions** | | |
| Item 35. | Exclusions vary by policy. A list of exclusions is available immediately upon request from your carrier, agent, or plan sponsor. Review the list to see if a service or treatment you may need is excluded from the policy. | Exclusions vary by policy. A list of exclusions is available immediately upon request from your carrier, agent, or plan sponsor. Review **them** to see if a service or treatment you may need is excluded from the policy. *[Company used "them" instead of "the list.] [Emphasis added.]* |
| **Part D: Using the Plan** | | |
| Item 37. | (1) "Yes" or (2) "No". If the answer is "Yes", a carrier may expand on the answer to note exceptions to this requirement (e.g., 'Yes, except for obstetrical or gynecological care.") | Prior notification is required for selected procedures. *[Company did not indicate "yes" or "no".]* |
| Item 39. | Enter your main customer service number for members/insureds. | Prior to receiving ID card, contact your Employer Benefits Administrator.<br>After receiving ID card, contact the Customer Service Department at the toll free number listed on your ID card<br>Sales and Marketing office – 800-516-3344 *[Company did not list customer service number.]* |
| Item 40. | Enter name, address and phone number for complaints and grievances. | Contact the Customer Service Department at toll free number listed on your ID card<br>UnitedHealthcare National Appeals Service Center P O Box 659773<br>San Antonio, TX 78265-9773<br>*[Company did not list phone number for complaints and grievances.]* |
| Endnote 1 | "Network" refers to . . . | "Network" refers to . . . |
| Endnote 3 | "Out-of-pocket maximum" means . . . | "Out-of-pocket maximum" means . . . |
| Endnote 7 | "Emergency care" means . . . | "Emergency care" means . . . |
| Endnote 9 | "Biologically based mental illnesses" | "Biologically based mental illnesses" |
| Endnote 10 | Waiver of pre-existing condition exclusions. | Waiver of pre-existing condition exclusions. |
| Endnote 11 | Grievances. | Grievances. |

[Note: Prescribed formatting for endnotes does not include an underline of the word or term being defined.]

All of the following five (5) Health Benefit Plan Description Forms:

LBA/PSB1 UnitedHealthcare Choice Plus HMO $10 office visit, 90/70 Plan,

LBB/PSB2 UnitedHealthcare Choice Plus HMO $15 office visit, 90/60 Plan,

LBC/PSB5 UnitedHealthcare Choice Plus HMO $15 office visit, 80/60 Plan,

LBD/PSB7 UnitedHealthcare Choice Plus HMO $20 office visit, $300 ded. 80/60 Plan, and

LBE/PSB8 UnitedHealthcare Choice Plus HMO $20 office visit, $750 ded. 80/60 Plan

include the same language and formatting inconsistencies as noted in the column labeled "Company Used" and in the section labeled "Endnotes":

| | **Required Information/Format:** | **Company Used:** |
|---|---|---|
| **Part A: Type of Coverage** | | |
| 3. Areas of CO | Plan is available in the following **areas**: | Plan is available in the following counties: *[Company specifies "counties" instead of "areas."]* |
| **Part B: Summary of Benefits** | | |
| Item 4. | 4. Deductible Type[2] | *[Company did not include 4. Deductible Type with superscript 2.]* |
| Item 4a. | 4a. ANNUAL DEDUCTIBLE[2a]<br>a) [Individual][Single][2b]<br>b) [Family] [Non-single][2c] | 4a. ANNUAL DEDUCTIBLE<br>a) Individual<br>b) Family<br>*[Company does not include superscripts 2a, 2b, or 2c.]* |
| Item 5. | 5. OUT-OF-POCKET ANNUAL MAXIMUM[3]<br>a) Individual<br>b) Family<br>c) Is deductible included in the out-of-pocket maximum? | 5. OUT-OF-POCKET ANNUAL MAXIMUM[2]<br>a) Individual<br>b) Family<br>*[Company uses superscript 2 instead of 3 and did not include "c)".]* |
| Item 8. | 8. MEDICAL OFFICE VISITS[4]<br>a) Primary Care Providers<br>b) Specialists | 8. ROUTINE MEDICAL OFFICE VISTS<br>*[Name of item is incorrect and does not include superscript 4, and "a) and b)" were not included.]* |
| Item 10. | 10. MATERNITY<br>a) Prenatal Care<br>b) Delivery & inpatient well baby care[5] | 10. MATERNITY<br>a) Prenatal Care<br>b) Delivery& Inpatient well baby care<br>*[Company did not include* |

| | | |
|---|---|---|
| | | *superscript 5.]* |
| Item 10. | 10. MATERNITY<br>a) Prenatal Care<br>b) Delivery & inpatient well baby care[5] | 10. MATERNITY<br>a) Prenatal Care<br>b) Delivery& Inpatient well baby care<br>*[Company did not include superscript 5.]* |
| Item 11. | 11. PRESCRIPTION DRUGS[6] | 11. PRESCRIPTION DRUGS<br>*[Company did not include superscript 6.]* |
| Item 14. | 14. DIAGNOSTICS<br>a) Laboratory & x-ray<br>b) MRI, nuclear medicine, and other high-tech services | 14. LABORATORY AND X-RAY<br>*[Name of item is incorrect, and "a) and b)" were not included.]* |
| Item 15. | 15. EMERGENCY CARE[7,8] | 14. EMERCENCY CARE[3]<br>*[Company used superscript 3 and did not include superscripts 7 & 8.]* |
| Item 18. | 18. BIOLOGICALLY-BASED MENTAL ILLNESS CARE[9] | 18. BIOLOGICALLY-BASED MENTAL ILLNESS[4] CARE<br>*[Company used superscript 4 instead of 9.]* |

**Part C: Limitations and Exclusions**

| | | |
|---|---|---|
| Item 32. | 32. PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED.[10] | 32. PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED.[5]<br>*[Company used incorrect superscript. Should be 10 and not 5.]* |
| Item 35. | Exclusions vary by policy. A list of exclusions is available immediately upon request from your carrier, agent, or plan sponsor. Review the list to see if a service or treatment you may need is excluded from the policy. | Exclusions vary by policy. A list of exclusions is available immediately upon request from your carrier, agent, or plan sponsor. Review **them** to see if a service or treatment you may need is excluded from the policy.<br>*[Company used "them" instead of "the list".] [Emphasis added.]* |

**Part D: Using the Plan**

| | | |
|---|---|---|
| Item 37. | (1) "Yes" or (2) "No". If the answer is "Yes", a carrier may expand on the answer to note exceptions to this requirement (e.g., 'Yes, except for obstetrical or gynecological care.") | Prior notification is required for selected procedures. *[Company did not indicate "yes" or "no".]* |
| Item 39. | Enter your main customer service number for members/insureds. | Prior to receiving ID card, contact your Employer Benefits Administrator.<br>After receiving ID card, contact the Customer Service Department |

| | | |
|---|---|---|
| | | at the toll free number listed on your ID card<br>Sales and Marketing office – 800-516-3344 *[Company did not list customer service number.]* |
| Item 40. | Enter name, address and phone number for complaints and grievances. | Contact the Customer Service Department at toll free number listed on your ID card<br>UnitedHealthcare National Appeals Service Center P O Box 659773<br>San Antonio, TX 78265-9773<br>*[Company did not list phone number for complaints and grievances.]* |
| Item 43. | Indicate, with a "Yes" or "No", if the plan has binding arbitration. | *[Company did not include correct question for Item 43. See Below. Instead, Company included Parts E and F that are not in the required format.]* |

| | |
|---|---|
| **PART E: COST AND MEDICAL EXPENDITURES**<br><br>43. What is the cost of this plan? | Contact your agent, this insurance company, or your employer, as appropriate, to find out the premium for this plan. In some cases, plan costs are included with this form . |

**PART F: PHYSICIAN PAYMENT METHODS, AND PLAN EXPENDITURES FOR HEALTH EXPENSES, ADMINISTRATION AND PROFIT Any person interested in applying for coverage, or who is covered by, or who purchased coverage under this plan may request answers to the questions listed below. The request may be made orally or in writing to the agent marketing the plan or directly to the insurance company and shall be answered within five (5) working days of the receipt of the request.**

- What are the three most frequently used methods of payment for primary care physicians?
- What are the three most frequently used methods of payment for physician specialists?
- What other financial incentives determine physician payment?
- What percentage of total Colorado premiums are spent on health care expenses as distinct from administration and profit?

Endnotes

The Company's endnotes include the following inconsistencies:

1. "Network" should not be underlined.
2. "Deductible Type" should be included, but is not.

2a "Deductible" should be included, but is not.
2b "Individual" should be included, but is not.
2c "Family" should be included, but is not.

3. "Out-of-pocket maximum" should not be underlined, and is included as Endnote 2 instead
4. Medical office visit . . . should be included, but is not.
5. Well baby care includes . . . should be included, but is not.
6. Prescription drugs . . . should be included, but is not.
7. "Emergency care" should not be underlined, and is included as Endnote 3 instead of 7.
8. Non-emergency care should be included, but is not.

9. "Biologically based mental illnesses" should not be underlined, and is included as Endnote 4 instead of 9.
10. Waiver of pre-existing exclusions, should not be underlined, and is included as Endnote 5 instead of 10.
11. Grievances, should not be underlined, and is included as Endnote 6 instead of 11.

**Description Form Names**
UnitedHealthcare Choice Plan LOC
Basic HMO Choice Plan JDJ
Standard HMO Choice Plan JDJ
LBA/PSB1 UnitedHealthcare Choice Plus HMO $10 office visit, 90/70 Plan
LBB/PSB2 UnitedHealthcare Choice Plus HMO $15 office visit, 90/60 Plan
LBC/PSB5 UnitedHealthcare Choice Plus HMO $15 office visit, 80/60 Plan
LBD/PSB7 UnitedHealthcare Choice Plus HMO $20 office visit, $300 ded. 80/60 Plan
LBE/PSB8 UnitedHealthcare Choice Plus HMO $20 office visit, $750 ded. 80/60 Plan

**Recommendation No. 13:**

No later than thirty (30) days from the date this report is adopted, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulations 4-2-20, Emergency Regulation 08-E-12 and Amended Regulation 4-6-5. In the event the Company is unable to show such proof, it should provide written evidence to the Division that it has implemented procedures to ensure that all its Colorado Health Benefit Plan Description Forms are in compliance with Colorado insurance law.

**Issue E13: Failure to reflect that coverage is provided for the full cost of cervical cancer vaccination for all females for whom a vaccination is recommended.**

Section 10-16-104, C.R.S., Mandatory coverage provisions - definitions, states in part:

(17) Cervical cancer vaccines.

(a) All individual and all group sickness and accident insurance policies, except supplemental policies covering specified diseases or other limited benefit, that are delivered or issued for delivery within the state by an entity subject to the provisions of part 2 of this article and all individual and group health care service or indemnity contracts issued by an entity subject to the provisions of part 3 or 4 of this article, as well as any group health care covered offered in this state, *shall provide coverage for the full cost of cervical cancer vaccination for all females for whom a vaccination is recommended by the advisory committee on immunization practices of the United States department of health and human services.* [Emphasis added.]

(b) The requirements of this subsection (17) shall apply to all individual sickness and accident insurance policies and health care service or indemnity contracts issued on or after January 1, 2008, and to all group accident and sickness policies and group health care service or indemnity contract issued, renewed, or reinstated on or after January 1, 2008.

(c) For purposes of this subsection (17), "sickness and accident insurance policy" does not include short-term, accident, fixed indemnity, specified disease policies or disability income contracts, and limited benefit or credit disability insurance, or such other insurance as described in section 10-18-101(3) or by the commissioner. The term also does not include insurance arising out of the "Workers' Compensation Act of Colorado", articles 40 to 47 of title 8, C.R.S., or other similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and which is required by law to be contained in a liability insurance policy or equivalent self-insurance.

(d) The health care service plan issued by an entity subject to the provisions of part 4 of this article may provide that the benefits provided pursuant to this subsection (17) shall be covered benefits only if the services rendered by a provider who is designated by and affiliated with the health maintenance organization.

It appears that the Company is not in compliance with Colorado insurance law in that the description in Section 1: What's Covered – Benefits does not include cervical cancer vaccination for all females for whom a vaccination is recommended by the advisory committee. In addition, the insurer is to provide the coverage at full cost, meaning the vaccination is not subject to payment of the Annual Deductible.

The Company's 2004 Choice Certificate of Coverage, form number CHOICECO.01 (12-2003), applicable to policies issued in the 2009 – 2001 Series Group, states in part:

2. Physician's Office Services

Covered Health Services received in a Physician's office including:

- Treatment of a Sickness or Injury.
- Preventive medical care.
- Voluntary family planning.
- Well-baby and well-child care.
- Routine physical examinations.
- Vision and hearing screenings. (Vision screenings do not include refractive examinations to detect vision impairment. See *Eye Examinations* earlier in this section.)
- Immunizations.

State Mandate

- Child Health Supervision Services
- Pap smears.

Benefits for prostate cancer screening include:

- One prostate examination per calendar year for Covered Persons age 50 and over.
- One prostate examination per calendar year for Covered Persons age 40 and over who are in high risk categories, as determined by a Network Physician.

Benefits for mammograms include:

- A baseline mammogram for women 35 through 39 years of age.
- A mammogram every two years for women 40 through 49 years of age.
- An annual mammogram (and clinical breast examination) for women 50 years of age or older.

An annual mammogram (and clinical breast examination) for women 40 years or older who have risk factors, as determined by a Network Physician.

**Form amended effective August 21, 2009.** The Company's amended form does not appear to comply with Colorado insurance law in that the description in Section 1: What's Covered – Benefits does not include cervical cancer vaccination for all females for whom a vaccination is recommended by the advisory committee. In addition, the insurer is to provide the coverage at full cost, meaning the vaccination is not subject to payment of the Annual Deductible.

The Company's MCE 2009 Amendment – Choice/Select (HMO) – 2001 Series, form number MCE09AMD.H.01.CO, applicable to the 2009 – 2001 Series Groups, includes the following:

Physician's Office Services

Covered Health Services for preventive medical care.

Preventive medical care includes:

- Voluntary family planning.
- Well-baby and well-child care.
- Routine physical examinations.

- Vision and hearing screenings. (Vision screenings do not include refractive examinations to detect vision impairment. See *Eye Examinations* earlier in this section.)
- Immunizations. Immunization deficient children are not bound by "recommended ages."
- Child Health Supervision Services.
- Pap smears.
- Prostate cancer screenings, including:
  - One prostate examination per calendar year for Covered Persons age 50 and over.
  - One prostate examination per calendar year for Covered Persons age 40 and over who are in high risk categories, as determined by a Network Physician.
- Mammogram screenings, including:
  - A baseline mammogram for women 35 through 39 years of age.
  - A mammogram every two years for women 40 through 49 years of age.
  - An annual mammogram (and clinical breast examination) for women 50 years of age or older.

An annual mammogram (and clinical breast examination) for women 40 years or older who have risk factors, as determined by a Network Physician.

| **Form** | **Form Number** |
|---|---|
| 2004 Choice Certificate of Coverage | CHOICECO.01 (12-2003), |
| **Amended Form** | **Amended Form Number** |
| MCE 2009 Amendment – Choice/Select (HMO) – 2001 Series | MCE09AMD.H.01.CO |

**Recommendation No. 14:**

No later than thirty (30) days from the date this report is adopted, the Company should provide documentation demonstrating why it should not be considered in violation of §10-16-104, C.R.S. In the event the Company is unable to show such proof, it should provide written evidence to the Division that it has revised its forms to reflect coverage for the full cost of cervical cancer vaccination is provided for all females for whom a vaccination is recommended by the advisory committee on immunization practices of the United States department of health and human services, in accordance with Colorado insurance law.

**Issue E14: Failure to reflect the correct percentage payable by the Company for durable medical equipment under the basic and standard health benefit plans.**

Emergency Regulation 08-E-12 (effective 1/1/09), Concerning Small Employer Group Health Benefit Plans and The Basic and Standard Health Benefit Plans, promulgated under the authority of §§ 10-1-109, 10-16-105 (7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states in part:

Section 2 Scope and Purpose

The purpose of this emergency regulation is to comply with the enactment of Senate Bill 08-057, which mandates coverage of hearing aids for children under the age of 18 and House Bill 08-1410, concerning the coverage of colorectal cancer prevention services. This emergency regulation specifies the requirements for the basic and standard health benefit plans as well as other requirements for small employer carriers.

Section 3 Applicability

This regulation shall apply to all small employer carriers as defined in §10-16-102(41), C.R.S., and to all carriers required to provide conversion products pursuant to §10-16-108, C.R.S.

BASIC AND STANDARD HEALTH BENEFIT PLAN POLICY REQUIREMENTS FOR THE STATE OF COLORADO

Colorado Division of Insurance

Effective January 1, 2009

1. The basic health benefit plan as defined by the Commissioner pursuant to § 10-16-105(7.2)(b), C.R.S., for an indemnity, preferred provider organization (PPO), and health maintenance organization (HMO) plan shall include the specific benefits and coverages outlined in one of the attached tables labeled "Basic Limited Mandate Health Benefit Plan", Basic HSA Health Benefit Plan", or "Basic HSA Limited Mandate Health Benefit Plan".

2. The standard health benefit plan for an indemnity, PPO, and HMO plan shall include the specific benefits and coverages outlined in the attached table labeled "Standard Health Benefit Plan"

…

Benefit Grid

JANUARY 1, 2009 COLORADO BASIC LIMITED MANDATE HEALTH BENEFIT PLANS:
INDEMNITY, PPO, AND HMO

PART A: TYPES OF COVERAGE

| | BASIC HMO PLAN |
|---|---|
| 22. DURABLE MEDICAL EQUIPMENT [17] | 30% copay $1,000/year maximum |

Footnote: 17 Coverage for lesser of purchase or rental price for medically necessary durable medical equipment. DME includes, but is not limited to, home-administered oxygen and reusable equipment for the treatment of diabetes. **The cost of prosthetics does not apply to the annual DME maximum.** The benefit level for prosthetic devices for arms or legs or parts thereof shall be as required by § 10-16-104(14), C.R.S. Repair or replacement of defective equipment is covered at no additional charge; repair and replacement needed because of normal usage is covered, but repair and replacement due to misuse/abuse by the insured is ***not*** covered. [Emphasis added.]

JANUARY 1, 2009 COLORADO STANDARD HEALTH BENEFIT PLANS: INDEMNITY, PPO, AND HMO

PART A: TYPES OF COVERAGE

| | STANDARD HMO PLAN |
|---|---|
| 22. DURABLE MEDICAL EQUIPMENT [21] | 20% copay $2,000/year maximum |

Footnote: 21 Coverage for lesser of purchase or rental price for medically necessary durable medical equipment. DME includes, but is not limited to, home-administered oxygen and reusable equipment for the treatment of diabetes. The cost of prosthetics does not apply to the annual DME maximum. The benefit level for prosthetic devices for arms or legs or parts thereof shall be as required by § 10-16-104(14), C.R.S. Repair or replacement of defective equipment is covered at no additional charge; repair and replacement needed because of normal usage is covered, but repair and replacement due to misuse/abuse by the insured is not covered. [Emphasis added.]

Colorado Insurance Regulation 4-6-5 (effective2/1/09), Concerning Small Employer Group Health Benefit Plans and The Basic and Standard Health Benefit Plans, promulgated under the authority of §§ 10-1-109, 10-16-105 (7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states in part:

. . .

Section 2 Scope and Purpose

The purpose of this amendment is to comply with the enactment of Senate Bill 08-057, which mandates coverage of hearing aids for children under the age of 18 and House Bill 08-1410, concerning the coverage of colorectal cancer prevention services. *This regulation specifies the requirements for the basic and standard health benefit plans as well as other requirements for small employer carriers*. This regulation replaces Emergency Regulation 08-E-12 in its entirety. [Emphasis added.]

Section 3 Applicability

This regulation shall apply to all small employer carriers as defined in § 10-16-102(41), C.R.S. and to all carriers required to provide conversion products pursuant to § 10-16-108, C.R.S.

BASIC AND STANDARD HEALTH BENEFIT PLAN POLICY REQUIREMENTS FOR THE STATE OF COLORADO

Colorado Division of Insurance

Effective February 1, 2009

1. The basic health benefit plan as defined by the Commissioner pursuant to § 10-16-105(7.2)(b), C.R.S., for an indemnity, preferred provider organization (PPO), and health maintenance organization (HMO) plan shall include the specific benefits and coverages outlined in one of the attached tables labeled "Basic Limited Mandate Health Benefit Plan", Basic HSA Health Benefit Plan", or "Basic HSA Limited Mandate Health Benefit Plan".

. . .

2. The standard health benefit plan for an indemnity, PPO, and HMO plan shall include the specific benefits and coverages outlined in the attached table labeled "Standard Health Benefit Plan"

Benefit Grid

FEBRUARY 1, 2009 COLORADO BASIC LIMITED MANDATE HEALTH BENEFIT PLANS:
INDEMNITY, PPO, AND HMO

PART A: TYPES OF COVERAGE

| | BASIC HMO PLAN |
|---|---|
| 22. DURABLE MEDICAL EQUIPMENT [17] | 30% copay $1,000/year maximum |

Footnote: 17 Coverage for lesser of purchase or rental price for medically necessary durable medical equipment. DME includes, but is not limited to, home-administered oxygen and reusable equipment for the treatment of diabetes. **The cost of prosthetics does not apply to the annual DME maximum.** The benefit level for prosthetic devices for arms or legs or parts thereof shall be as required by § 10-16-104(14), C.R.S. Repair or replacement of defective equipment is covered at no additional charge; repair and replacement needed because of normal usage is covered, but repair and replacement due to misuse/abuse by the insured is ***not*** covered. [Emphasis added.]

FEBRURY 1, 2009 COLORADO STANDARD HEALTH BENEFIT PLANS:
INDEMNITY, PPO, AND HMO

PART A: TYPES OF COVERAGE

| | STANDARD HMO PLAN |
|---|---|
| 22. DURABLE MEDICAL EQUIPMENT [21] | 20% copay $2,000/year maximum |

Footnote: 21 Coverage for lesser of purchase or rental price for medically necessary durable medical equipment. DME includes, but is not limited to, home-administered oxygen and reusable equipment for the treatment of diabetes. The cost of prosthetics does not apply to the annual DME maximum. The benefit level for prosthetic devices for arms or legs or parts thereof shall be as required by § 10-16-104(14), C.R.S. Repair or replacement of defective equipment is covered at no additional charge; repair and replacement needed because of normal usage is covered, but repair and replacement due to misuse/abuse by the insured is not covered. [Emphasis added.]

It appears that the Company's Schedule of Benefits, as described below, includes information that is not in compliance with Colorado insurance law as follows:

The Company's Hearing Aid Rider Basic and Standard HMO, form number

1109HEARINGAID.BSCSTD.AMD.H.07.CO, includes an amendment to the Schedule of Benefits effective January 1, 2009, in which the benefit for Durable Medical Equipment is incorrectly shown as 30% instead of 70%:

[3. The provision below for Durable Medical Equipment in the *Schedule of Benefits* is replaced with the following:]

| **Covered Health Service** | **Benefit** ***(The Amount We Pay, based on Eligible Expenses)*** |
|---|---|
| **[#.] Durable Medical Equipment** | |
| Limited to $1,000 in Eligible Expenses per year. Benefits are limited to a single purchase of a type of DME (including repair/replacement) as necessary. You must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician. | 30% |

**Forms amended effective August 21, 2009.** It appears that the Company's Schedule of Benefits, as described below, includes information that is not in compliance with Colorado insurance law as follows:

The Company's amended form MCE 2009 Correction – Standard HMO SB Medical SOB, form number SBN.CHC1.H.07.CO.STD, in which the benefit for Durable Medical Equipment incorrectly indicates 20% instead of 80%:

| **Covered Health Service** | **Benefit** ***(The Amount We Pay, based on Eligible Expenses)*** |
|---|---|
| **[4.] Durable Medical Equipment** | |
| Limited to $2,000 in Eligible Expenses per year. Benefits are limited to a single purchase of a type of DME (including repair/replacement) as necessary. You must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician. | 20% [Emphasis added.] |

| **Forms** | **Form Numbers** |
|---|---|
| Hearing Aid Rider Basic and Standard HMO | 1109HEARINGAID.BSCSTD.AMD.H.07.CO |

| **Amended Form** | **Amended Form Number** |
|---|---|
| MCE 2009 Correction – Standard HMO SB Medical SOB | SBN.CHC1.H.07.CO.STD |

**Recommendation No. 15:**

No later than thirty (30) days from the date this report is adopted, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Emergency Regulation 08-E-12 and Amended Insurance Regulation 4-6-5. In the event the Company is unable to show such proof, it should provide written evidence to the Division that it has revised and implemented its Schedules of Benefits for both the basic and standard health benefit plans to reflect the correct percentage payable by the Company for durable medical equipment, in accordance with Colorado insurance law.

**Issue E15: Failure to reflect the correct percentage payable by the Company for prosthetic devices.**

Emergency Regulation 08-E-12 (effective 1/1/09, Concerning Small Employer Group Health Benefit Plans and The Basic and Standard Health Benefit Plans, promulgated under the authority of §§ 10-1-109, 10-16-105 (7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states:

Section 2 Scope and Purpose

The purpose of this emergency regulation is to comply with the enactment of Senate Bill 08-057, which mandates coverage of hearing aids for children under the age of 18 and House Bill 08-1410, concerning the coverage of colorectal cancer prevention services. This emergency regulation specifies the requirements for the basic and standard health benefit plans as well as other requirements for small employer carriers.

Section 3 Applicability

This regulation shall apply to all small employer carriers as defined in §10-16-102(41), C.R.S., and to all carriers required to provide conversion products pursuant to §10-16-108, C.R.S.

BASIC AND STANDARD HEALTH BENEFIT PLAN POLICY REQUIREMENTS FOR THE STATE OF COLORADO

Colorado Division of Insurance

Effective January 1, 2009

3. The basic health benefit plan as defined by the Commissioner pursuant to § 10-16-105(7.2)(b), C.R.S., for an indemnity, preferred provider organization (PPO), and health maintenance organization (HMO) plan shall include the specific benefits and coverages outlined in one of the attached tables labeled "Basic Limited Mandate Health Benefit Plan", Basic HSA Health Benefit Plan", or "Basic HSA Limited Mandate Health Benefit Plan".

Benefit Grid

JANUARY 1, 2009 COLORADO BASIC LIMITED MANDATE HEALTH BENEFIT PLANS:
INDEMNITY, PPO, AND HMO

PART A: TYPES OF COVERAGE

| | BASIC HMO PLAN |
|---|---|
| 22. DURABLE MEDICAL EQUIPMENT [17] | 30% copay $1,000/year maximum |

Footnote: 17 Coverage for lesser of purchase or rental price for medically necessary durable medical equipment. DME includes, but is not limited to, home-administered oxygen and reusable equipment for the treatment of diabetes. The cost of prosthetics does not apply to the annual DME maximum. The benefit level for prosthetic devices for arms or legs or parts thereof shall be as required by § 10-16-104(14), C.R.S. Repair or replacement of defective equipment is covered at no

additional charge; repair and replacement needed because of normal usage is covered, but repair and replacement due to misuse/abuse by the insured is not covered.

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| 31. SIGNIFICANT ADDITIONAL SERVICES (List up to 5).<br>a) Hearing Aids[19a] |

Footnote 19a As of January 1, 2009, hearing aids for dependent children under the age of 18 are covered in compliance with §10-16-104(19), C.R.S. The coverage includes the initial assessment, fitting, adjustments, and the required auditory training. Initial hearing aids and replacements hearing aids are not covered more frequently than every (5) years; however, a new hearing aid is covered when alterations to the existing hearing aid cannot adequately meet the needs of the child. ***Hearing aids are not considered to be durable medical equipment.*** Benefits shall be provided in the same manner as the same types of services for all other covered conditions and are determined by where the hearing aid is accessed (i.e. an office visit copay will apply if the hearing aid is provided as part of an office visit). Hearing aids are subject to utilization review as provided in §§ 10-16-12, 10-16-13, and 10-16-113.5, C.R.S. [Emphasis added.]

JANUARY 1, 2009 COLORADO STANDARD HEALTH BENEFIT PLANS: INDEMNITY, PPO, AND HMO

PART A: TYPES OF COVERAGE

| | STANDARD HMO PLAN |
|---|---|
| 22. DURABLE MEDICAL EQUIPMENT [21] | 20% copay $2,000/year maximum |

Footnote: 21 Coverage for lesser of purchase or rental price for medically necessary durable medical equipment. DME includes, but is not limited to, home-administered oxygen and reusable equipment for the treatment of diabetes. The cost of prosthetics does not apply to the annual DME maximum. The benefit level for prosthetic devices for arms or legs or parts thereof shall be as required by § 10-16-104(14), C.R.S. Repair or replacement of defective equipment is covered at no additional charge; repair and replacement needed because of normal usage is covered, but repair and replacement due to misuse/abuse by the insured is not covered. [Emphasis added.]

Colorado Insurance Regulation 4-6-5 (effective2/1/09), Concerning Small Employer Group Health Benefit Plans and The Basic and Standard Health Benefit Plans, promulgated under the authority of §§ 10-1-109, 10-16-105 (7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states:

Section 2 Scope and Purpose

The purpose of this amendment is to comply with the enactment of Senate Bill 08-057, which mandates coverage of hearing aids for children under the age of 18 and House Bill 08-1410, concerning the coverage of colorectal cancer prevention services. *This regulation specifies the requirements for the basic and standard health benefit plans as well as other requirements for small employer carriers*. This regulation replaces Emergency Regulation 08-E-12 in its entirety. [Emphasis added.]

Section 3 Applicability

This regulation shall apply to all small employer carriers as defined in § 10-16-102(41), C.R.S. and to all carriers required to provide conversion products pursuant to § 10-16-108, C.R.S.

BASIC AND STANDARD HEALTH BENEFIT PLAN POLICY REQUIREMENTS FOR THE STATE OF COLORADO

Colorado Division of Insurance

Effective February 1, 2009

1. The basic health benefit plan as defined by the Commissioner pursuant to § 10-16-105(7.2)(b), C.R.S., for an indemnity, preferred provider organization (PPO), and health maintenance organization (HMO) plan shall include the specific benefits and coverages outlined in one of the attached tables labeled "Basic Limited Mandate Health Benefit Plan", Basic HSA Health Benefit Plan", or "Basic HSA Limited Mandate Health Benefit Plan".

Benefit Grid

FEBRUARY 1, 2009 COLORADO BASIC LIMITED MANDATE HEALTH BENEFIT PLANS:
INDEMNITY, PPO, AND HMO

PART A: TYPES OF COVERAGE

| | BASIC HMO PLAN |
|---|---|
| 22. DURABLE MEDICAL EQUIPMENT [17] | 30% copay $1,000/year maximum |

Footnote: 17 Coverage for lesser of purchase or rental price for medically necessary durable medical equipment. DME includes, but is not limited to, home-administered oxygen and reusable equipment for the treatment of diabetes. The cost of prosthetics does not apply to the annual DME maximum. The benefit level for prosthetic devices for arms or legs or parts thereof shall be as required by § 10-16-104(14), C.R.S. Repair or replacement of defective equipment is covered at no additional charge; repair and replacement needed because of normal usage is covered, but repair and replacement due to misuse/abuse by the insured is not covered.

| |
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| 31. SIGNIFICANT ADDITIONAL SERVICES (List up to 5). |
| a) Hearing Aids[19a] |

Footnote 19a As of January 1, 2009, hearing aids for dependent children under the age of 18 are covered in compliance with §10-16-104(19), C.R.S. The coverage includes the initial assessment, fitting, adjustments, and the required auditory training. Initial hearing aids and replacements hearing aids are not covered more frequently than every (5) years; however, a new hearing aid is covered when alterations to the existing hearing aid cannot adequately meet the needs of the child. ***Hearing aids are not considered to be durable medical equipment.*** Benefits shall be provided in the same manner as the same types of services for all other covered conditions and are determined by where the hearing aid is accessed (i.e. an office visit copay will apply if the hearing aid is provided as part of an office visit).

Hearing aids are subject to utilization review as provided in §§ 10-16-12, 10-16-13, and 10-16-113.5, C.R.S. [Emphasis added.]

FEBRURY 1, 2009 COLORADO STANDARD HEALTH BENEFIT PLANS: INDEMNITY, PPO, AND HMO

PART A: TYPES OF COVERAGE

| | STANDARD HMO PLAN |
|---|---|
| 22. DURABLE MEDICAL EQUIPMENT [21] | 20% copay $2,000/year maximum |

Footnote: 21 Coverage for lesser of purchase or rental price for medically necessary durable medical equipment. DME includes, but is not limited to, home-administered oxygen and reusable equipment for the treatment of diabetes. The cost of prosthetics does not apply to the annual DME maximum. The benefit level for prosthetic devices for arms or legs or parts thereof shall be as required by § 10-16-104(14), C.R.S. Repair or replacement of defective equipment is covered at no additional charge; repair and replacement needed because of normal usage is covered, but repair and replacement due to misuse/abuse by the insured is not covered. [Emphasis added.]

It appears that the Company's Schedule of Benefits, as described below, includes information that is not in compliance with Colorado insurance law as follows:

The Company's Hearing Aid Rider Basic and Standard HMO, form number 1109HEARINGAID.BSCSTD.AMD.H.07.CO, includes an amendment to the Schedule of Benefits effective January 1, 2009, in which the benefit is incorrectly shown as 30% instead of 70%.

[4]. The provision below for Prosthetic Devices in the *Schedule of Benefits* is replaced with the following:

| **Covered Health Service** | **Benefit** ***(The Amount We Pay, based on Eligible Expenses)*** |
|---|---|
| **[#.] Prosthetic Devices** | |
| Benefits are limited to a single purchase of each type of prosthetic device. Prosthetic devices are not subject to the DME limit.<br>Items required by the Women's Health and Cancer Rights Act of 1998 and for prosthetic arms, legs, feet and hands are not subject to the DME limit. | *30%* [Emphasis added.] |

**Forms amended effective August 21, 2009.** It appears that the Company's Schedule of Benefits, as described below, include information that is not in compliance with Colorado insurance law as follows:

The Company's amended form SBN-Medical-HMO-2007-Choice Standard-SB-Rev1, form number SBN.CHC1.H.07.CO.STD, in which the benefit is incorrectly shown at 20% instead of 80%.

| **Covered Health Service** | **Benefit** ***(The Amount We Pay, based on Eligible Expenses)*** |
|---|---|
| **[16.] Prosthetic Devices** | |

| | |
|---|---|
| Benefits are limited to a single purchase of each type of prosthetic device. Prosthetic devices are not subject to the DME limit.<br><br>Items required by the Women's Health and Cancer Rights Act of 1998 and for prosthetic arms, legs, feet and hands are not subject to the DME limit. | *20%* [Emphasis added.] |

| **Forms** | **Form Numbers** |
|---|---|
| Hearing Aid Rider Basic and Standard HMO | 1109HEARINGAID.BSCSTD.AMD.H.07.CO |
| **Amended Form** | **Amended Form Number** |
| SBN-Medical-HMO-2007-Choice Standard-SB-Rev1 | SBN.CHC1.H.07.CO.STD |

**Recommendation No. 16:**

No later than thirty (30) days from the date this report is adopted, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Emergency Regulation 08-E-12 and Amended Insurance Regulation 4-6-5. In the event the Company is unable to show such proof, it should provide written evidence to the Division that it has revised its Schedule of Benefits to reflect the correct percentage to be paid by the Company for prosthetic devices, in accordance with Colorado insurance law.

**Issue E16: Failure to reflect benefits and exclusions pertaining to clinical trials that are consistent with mandatory coverage provisions.**

Section 10-16-104, C.R.S., Mandatory coverage provisions, states:

(20) Clinical trials and studies.

(a) All individuals and group health benefit plans shall provide coverage for routine patient care costs that a policy or certificate holder, or his or her dependent, receives during a clinical trial if:

(I) The covered person's treating physician, who is providing covered health care services to the person under the health benefit plan contract, recommends participation in the clinical trial after determining that participation in the clinical trial has the potential to provide a therapeutic health benefit to the covered person.

(II) The clinical trial or study is approved under the September 19, 2000, medicare national coverage decision regarding clinical trials, as amended;

(III) The patient care is provided by a certified, registered, or licensed health care provider practicing within the scope of his or her practice and the facility and personnel providing the treatment have the experience and training to provide the treatment in a competent manner;

(IV) Prior to participation in a clinical trial or study, the covered person has signed a statement of consent indicating that the covered person has been informed of the procedure to be undertaken, alternative methods of treatment, the general nature and extent of the risks associated with participation in the clinical trial or study, the coverage provided by an individual or group health benefit plan will be consistent with the coverage provided in the covered person's health benefit plan, and all out-of-network rates will apply; and

(V) The covered person suffers from a condition that is disabling, progressive, or life-threatening.

(b) The coverage required pursuant to paragraph (a) of this subsection (20) does not include:

(I) Any portion of the clinical trial or study that is paid for by a government or a biotechnical, pharmaceutical, or medical industry;

(II) Coverage for any drug or device that is paid for by the manufacturer, distributor, or provider of the drug or device;

(III) Extraneous expenses related to participation in the clinical trial or study including, but not limited tom travel, housing, and other expenses that a participant or person accompanying a participant may incur;

(IV) An item or service that is provided solely to satisfy a need for data collection or analysis that is not directly related to the clinical management of the participant;

(V) Costs for management of research relating to the clinical trial or study; or

(VI) Health care services that, except for the fact that they are provided in a clinical trial, are otherwise specifically excluded from coverage under the covered person's health plan.

(c) Nothing in this subsection (20) shall:

(I) Preclude a carrier from asserting the right to seek reimbursement from the entity conducting the clinical trial or study for expenses arising from complications caused by a drug or device used in the clinical trial or study;

(II) Be interpreted to provide a private cause of action against a carrier for damages as a result of compliance this section.

(d) For the purposes of this section:

(I) "Clinical trial" means an experiment in which a drug or device is administered to, dispensed to, or used by one or more human subjects. An experiment may include the use of a combination of drugs as well as the use of a drug in combination with an alternative therapy or dietary supplement.

(II) "Routine patient care cost" means all items and services that are a benefit under a health coverage plan that would be covered if the covered person were not involved in either the experimental or the control arms of a clinical trial; except that investigational item or service, itself; items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; items and services customarily provided by the research sponsors free of charge for any enrollee in the trial; routine costs in clinical trials that include items or services that are typically provided absent a clinical trial; items or services required solely for the provision of the investigational items or services, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; and items or services needed for reasonable and necessary care arising from the provision of an investigational item or service, including the diagnosis or treatment of complications.

Colorado statute, § 10-16-104(20), C.R.S., was effective August 5, 2009. The Company advised its form, Clinical Trials Amendment – 2001 Series, form number CLINICALTRIALSAMD.H.01.CO, pertaining to the 2009 – 2001 Series Group Forms, was applicable to new and renewing plans on or after August 5, 2009, and that it was placed in use on April 1, 2010. In addition to the 2009 – 2001 Series Group Forms, this amendment should have been included in the Basic and Standard Health Benefit Plans that were issued or renewed after August 5, 2009.

The amendment also appears to be inconsistent with Colorado insurance law in that the language

describing the benefits is more restrictive in the following manner:

- It specifies the treatment of specific illnesses or disorders the Company considers meet its criteria for a qualifying Clinical Trial.
- It indicates Company can determine if clinical trials meets qualifications rather than relying on principal investigators who must certify that trials meet the qualifying criteria and enroll the trials on the Medicare clinical trials registry.
- It excludes benefits not specified in the law.
- It includes qualifying requirements not specified in the law. Neither Colorado Insurance law nor the Medical National Coverage Decision indicate that a clinical trial must be sponsored and provided by a cancer center or have a written protocol approved by all relevant institutional review boards.

The Company's Clinical Trials Amendment states:

> The following provision is added to the Certificate of Coverage, (Section 1: What's Covered--Benefits):
>
> Benefits:
> Clinical Trials
> Routine patient care costs incurred during participation in a qualifying Clinical Trial for the treatment of:
> - Cancer.
> - Cardiovascular disease (cardiac/stroke).
> - Surgical musculoskeletal disorders of the spine, hip and knees.
> - A Clinical Trial or study approved under the September 19, 2000, Medicare National Coverage Decision regarding Clinical Trials, as amended.
> - [[1]Other diseases or disorders for which, as we determine, a Clinical Trial meets the qualifying Clinical Trial criteria stated below.]
>
> Benefits include the reasonable and necessary items and services used to diagnose and treat complications arising from participation in a qualifying Clinical Trial.
>
> Benefits are available only when the Covered Person is clinically eligible for participation in the Clinical Trial as defined by the researcher. Benefits are not available for preventive Clinical Trials.
>
> Routine patient care costs for Clinical Trials include:
> - Covered Health Services for which Benefits are typically provided absent a Clinical Trial.
> - Covered Health Services required solely for the provision of the investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications.
> - Covered Health Services needed for reasonable and necessary care arising from the provision of an investigational item or service.
>
> Routine costs for Clinical Trials do not include:
> - The Experimental or Investigational Service or item. The only exceptions to this are:
>  --- Certain Category B devices.
>  --- Certain promising interventions for patients with terminal illnesses.
>  --- Other items and services that meet specified criteria in accordance with our medical policy guidelines.

- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
- Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

To be a qualifying Clinical Trial, a Clinical Trial must meet all of the following criteria:

- Be sponsored and provided by a cancer center that has been designated by the National Cancer Institute (NCI) as a Clinical Cancer Center or Comprehensive Cancer Center or be sponsored by any of the following:
  - National Institute of Health (NIH). (Includes National Cancer Institute (NCI).)
  - Centers for Disease Control and Prevention (CDC).
  - Agency for Healthcare Research and Quality (AHRQ).
  - Centers for Medicare and Medicaid Services (CMS).
  - Department of Defense (DOD).
  - Veterans Administration (VA).
- The Clinical Trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. We may, at any time, request documentation about the trial to confirm that the Clinical Trial meets current standards for scientific merit and is not otherwise excluded under the Policy.
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Policy.

Benefits include Covered Health Services provided in accordance with the Covered Person's treating Physician who is providing Covered Health Services after determining that participating in the Clinical Trial has the potential to provide a therapeutic health benefit to the Covered Person and meets all of the following criteria:

- The Clinical Trial or study is approved under the September 19, 2000, Medicare National Coverage Decision regarding Clinical Trials, as amended.
- The patient care is provided by a certified, registered, or licensed health care provider practicing within the scope of his or her practice and the facility and personnel providing the treatment have the experience and training to provide the treatment in a competent manner.
- Prior to participation in a Clinical Trial or study, the Covered Person has signed a statement of consent indicating that the Covered Person has been informed of the procedure to be undertaken, alternate methods of treatment, and the general nature and extent of the risks associated with participation in the Clinical Trial or study.
- The Covered Person suffers from a condition that is disabling, progressive, or life-threatening.

Coverage does not include:

- Any portion of the Clinical Trial or study that is paid for by a government or a biotechnical, pharmaceutical, or medical industry.
- Coverage for any drug or device that is paid for by the manufacturer, distributor, or provider of the drug or device.
- Extraneous expenses related to participation in the Clinical Trial or study including, but not limited to, travel, housing, and other expenses that a participant or person accompanying a participant may incur.
- An item or service that is provided solely to satisfy a need for data collection or analysis that is not directly related to the clinical management of the participant.
- Cost for the management of research relating to the Clinical Trial or study.
- Health care services that, except for the fact that they are being provided in a Clinical Trial,

are otherwise specifically excluded from coverage under the Covered Person's health plan.

| **Amended Form** | **Amended Form Number** |
|---|---|
| Clinical Trials Amendment – 2001 Series | CLINICALTRIALSAMD.H.01.CO |

**Recommendation No. 17:**

No later than thirty (30) days from the date this report is adopted, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-104, C.R.S. In the event the Company is unable to show such proof, it should provide written evidence to the Division that it has revised its Clinical Trials Amendment to reflect benefits and exclusions that are consistent with mandatory coverage provisions in accordance with Colorado insurance law.

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## Examination Report Submission

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